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# AN EXPLORATION OF REFUGEES, POST TRAUMATIC STRESS DISORDER AND QUALITY OF LIFE

## SECTION A:

## Refugee Post-migration: A Review of Post Traumatic Stress Disorder (PTSD), Grief, Resettlement and Quality of Life (QoL)

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## SECTION B:

## An Exploratory Narrative Study of the Quality of Life (QoL) of Refugees who Experience Post Traumatic Stress Disorder (PTSD)

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## SECTION C:

## Critical Appraisal

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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

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**Salomons**

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# Summary of Portfolio

**Section A**

This literature review aims to consolidate the theoretical and empirical psychological research regarding refugees' post-migration, to clarify and further understand their psychological experiences and needs. The literature search yielded papers which are divided into four sections: refugees and PTSD; refugees, complicated grief and cultural bereavement; refugees, resettlement and acculturation; and refugees and QoL. The review highlights key findings and areas requiring further exploration.

**Section B**

This exploratory narrative study aims to explore the role of QoL in the narratives of refugees with a diagnosis of PTSD. Episodic semi-structured interviews were conducted with seven refugees (5 males, 2 females), and analysed using narrative thematic, structural and performance analysis. The results illustrated containing and consistent support was important in progressing the transition from suffering during asylum-seeking to a refugee with hope, and improved QoL and psychological health. The results are applied to theory and research, and limitations of the study are discussed.

**Section C**

This paper critically appraises the exploratory narrative study and highlights the principal researcher's learning, what could be done differently, the possible impact of the research on clinical practice, and future research ideas for this area.

**Section D**

This section includes the appendices for the whole portfolio.

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# Section A

# Refugee Post-migration: A Review of Post Traumatic Stress Disorder (PTSD), Grief, Resettlement and Quality of Life (QoL)

**Word Count: 5499**

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## Abstract

Further clarity and understanding of traumatised refugees' post-migration psychological experiences may be important to ascertain how to better meet this population's psychological needs. The literature review aims to facilitate this by consolidating the extant theoretical and empirical research applicable to traumatised refugees post-migration. A literature search was conducted and the findings divided into four sections: refugees and PTSD; refugees, cultural bereavement and prolonged grief; refugees and resettlement; and refugees and quality of life (QoL). The review highlights key gaps in the literature, such as further empirical research being required for acculturation, and appropriate theoretical guidance for the QoL of refugees. The understanding of refugee post-migration is then used to discuss the efficacy of psychological interventions for traumatised refugees. The review indicates a clearer, holistic narrative of refugee post-migration is required which may enhance psychological treatment, and culminates with a critique of the area and suggestions for future qualitative research.

**Keywords:** Refugees, Post-traumatic Stress Disorder, Grief, Resettlement, Quality of Life

# Introduction

A refugee's life in a host country following traumatic life experiences can be difficult and complex, resulting in numerous difficulties (Patel & Kelly, 2006). In the UK specifically, refugees are reported to have significant levels of unmet psychological needs, which requires better understanding and more effective services and policies (McColl & Johnson, 2006; Misra, Connelly, & Majeed, 2006). Within this context, this review aims to consolidate and critique the pertinent theoretical and empirical literature to enable a clearer understanding of refugees' post-migration psychological experiences and needs. This understanding could be applied to enhance trauma-focused psychological interventions and outcomes, whilst identifying specific areas requiring further exploration.

## *Definitions*

An asylum-seeker is;

*'a person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded'* (Refugee Council , 2011).

Therefore an asylum-seeker has not yet been granted entitlement to remain in the host country.

A refugee is a person who;

'*owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…*' (Refugee Convention, 1951).

A refugee is a person whose application has successfully concluded and accordingly granted leave to remain (LTR). In the UK, there are different types of refugee statuses; the most common being Refugee Status with Indefinite LTR or Refugee Status with Limited Leave,

whereby the refugee is granted five years LTR, and once this nears expiration, a renewal application can be made (Brown, 2008).

Throughout this review the term 'host country' will refer to the country in which the asylum-seeker or refugee has fled to and is residing in.

### *Refugees and Asylum Seekers in the UK*

The UK currently hosts approximately 2% of the world's refugee population (Refugee Action, 2011), with 269, 363 refugees and 11,900 asylum-seekers (UNHCR, 2010). The top four countries of origin in quarter four of 2010 were Iran, Sri Lanka, Pakistan and Afghanistan. Further, of 17,790 applications, 21% were granted LTR, and 72% were refused (Refugee Council, 2011).

The UK Border Agency (UKBA - 2012) states an application for LTR should take approximately six months. During the application process, asylum-seekers are dispersed nationwide to temporary accommodation, and can access food vouchers and basic NHS services (Department of Health, 2012). Employment is not permitted and many people live in poverty (Refugee Council, 2009; Brown, 2008). Following a Home Office interview, a decision is made regarding whether LTR is granted. If not, an asylum-seeker can appeal the decision, meaning the application process can take far longer than six months.

Once LTR is granted, refugees can access employment, benefits, housing, and varying levels of integration support nationwide (Brown, 2008). Before this is established, any basic support provided whilst asylum-seeking is withdrawn, potentially leaving refugees temporarily destitute (ICAR, 2006). The government, however, has reiterated commitment to improving the QoL and integration of refugees (UKBA, 2009), but with recent budget cuts to refugee services, this may prove challenging (Hill, 2011).

### *Refugees and Mental Health*

The variance in worldwide prevalence of mental health (MH) difficulties for refugees is significantly large and focuses on the rates of depression, anxiety and PTSD (e.g. Tribe, 2002; Fazel, Wheeler & Danesh, 2005; Gerrittsen, Bramsen, Devillé, van Willigen, Hovens & van der Ploeg, 2006). Furthermore, much data appears to be reported according to the participant's country of origin (e.g. Laban, Gernaat, Komproe, van der Tweel & De Jong Joop, 2005; Turner, Bowie, Dunn, Shapo & Yule, 2003), meaning it can be difficult to ascertain accurate overall prevalence of MH difficulties for refugees in host countries.

However, a recent prevalence study (Fazel, Wheeler & Danesh, 2005), found the most commonly diagnosed MH difficulties for refugees in western countries were PTSD (9%), major depression (5%), and generalised anxiety disorder (4%). Refugees are also said to be at significant risk of co-morbid MH difficulties, as well as self-harm and suicide (Cohen, 2008; Robjant, Hassan & Katona, 2009). Amongst the general UK population, the point prevalence of depression was reported at 2.6% (NICE, 2009), generalised anxiety at 4.7% (The Health and Social Care Information Centre, 2009), and PTSD at 3% (McManus, Meltzer & Wessley, 2007). Comparatively, the prevalence rates for PTSD and depression particularly, appear significantly higher amongst the refugee population. These MH difficulties in the context of a long and uncertain period of asylum-seeking could mean refugee post-migration is significantly fraught.

### *Understanding Refugee Post-Migration*

Refugee post-migration may pose significant challenges to refugee psychological health. Kirmayer et al (2011) proposed post-migration may encompass an accumulation of difficulties which include pre-migration factors of experiences of trauma and loss of status; migration factors of further exposure to trauma, loss of family members and culture, and poverty; and post-migration factors of loss of social support, uncertainty of asylum-seeking and resettlement difficulties.

PTSD is a significant refugee post-migration difficulty (NICE, 2005), but the UK government's drive for increased QoL and integration (UKBA, 2009) appears more focussed on the practicalities of resettlement, such as access to services. These practical aspects are important; however, to facilitate better understanding of refugees' psychological needs, this review will focus on the applicable psychological theory and research. Further, as loss of family, social support and culture were highlighted by Kirmayer et al (2011), it was deemed important these aspects were incorporated to create a more holistic psychological representation of refugee post-migration.

## Search Strategy

The search terms were defined following the initial literature search which cited PTSD, grief, QoL, and resettlement (acculturation) as pertinent refugee post-migration issues. The search terms of prolonged and complicated grief, and cultural bereavement were identified from the broader grief literature as particular to refugees, whilst identity was highlighted from the PTSD and acculturation literature. The appropriate papers were identified using the search terms and abstracts. Papers considered relevant to understanding the psychological experience of refugee post-migration (theoretical and empirical) were selected. These were reviewed and consolidated to create a representation of refugees' post-migration psychological experiences, their psychological needs, and gaps in the literature.

## Literature Search

Four databases were searched: CINAHL (Ebsco), PsycINFO, Web of Knowledge, and Medline. The search terms (Appendix One) were limited to titles, keywords and abstracts. Only papers whereby the topic/participants were adult refugees or asylum-seekers, written in English (no funds were available for translation), and which addressed the specific topic areas of PTSD, prolonged grief, cultural bereavement, resettlement, acculturation and QoL within

post-migration were selected. Thirty-six papers (Appendix Two) were identified which covered theoretical and empirical (quantitative and qualitative) research, and three review papers (used for contextual and intervention information). The papers were consolidated according to the topic areas detailed above to facilitate clarity.

The term refugee will be used throughout this review. However, asylum-seeker research was included as this is a significant part of the refugee journey.

## Refugees and Post-Traumatic Stress Disorder

PTSD is an anxiety disorder which affects individuals who have experienced or witnessed a traumatic event (such as war or rape), and which left them feeling horror, fear and helplessness (DSM-IV, American Psychiatric Association, 1994). Following such an event, survivors may experience flashbacks and nightmares of the trauma (intrusions), agitation and being easily startled (hyperarousal), and avoid reminders of the trauma (avoidance - Blake, Weathers, Nagy, Kaloupek, Gusman, Charney & Keane, 1995), leaving the person feeling a sense of threat in the present context.

When considering refugees and PTSD, it is important to acknowledge ethno-cultural aspects, such as cultural beliefs and vulnerability to trauma (Marsella, 2010). These aspects appear lacking in the construct of PTSD due to the focus on Euro-American perspectives, which has led to the cultural validity of PTSD outside of western cultures being questioned (Chantler, 2011). For refugees, these ethno-cultural aspects may be significant when taking into account trauma associated with war, religion, and organised violence which have strong political and cultural contexts (Summerfield, 2001; Robjant & Fazel, 2010).

Bearing this in mind, ethno-cultural identity seems important. Specifically, Jobson & O'Kearney (2008) propose theoretical concepts of PTSD are reviewed as they reported those from interdependent cultures were less defined by their traumatic experiences, perhaps due to the impact of trauma on social roles. Jobson and O'Kearney (2008) suggest ethno-cultural

identity should be understood and explored within assessments and treatments to ensure interventions incorporate refugees' cultural needs, as well as reduce PTSD.

Furthermore, the types of trauma/s experienced by refugees, such as multiple traumas, war and torture, can be different in character and severity from traumas in western countries (Silove, 1999). Thus refugees may present with complex and challenging difficulties to treat effectively (Crumlish & O'Rourke, 2010). Additionally, a significant amount of time may have passed since the trauma/s by the time refugees access MH services. This alongside pre-migration, migration, and post-migration difficulties could mean the chronicity of PTSD is high (Palic & Elkit, 2011).

Previously, a significant relationship between post-migration difficulties and psychological distress was reported, specifically when accounting for the asylum-seeking process, poor socio-economic status, and a lack of social support (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004). Carswell, Blackburn and Barker (2011) quantitatively investigated the relationship between trauma, post-migration difficulties and psychological well-being amongst UK refugees. The authors reported increased PTSD symptoms were related to more traumatic events, and post-migration difficulties of struggles with adaptation, loss of culture, and low social support. Furthermore, adaptation difficulties (i.e. unemployment and poverty) were found to predict PTSD symptoms, with a loss of culture and lack of social support predicting general psychological distress.

Further to this, a recent quantitative study highlighted the association between PTSD, post-migration stress (e.g. separation from family and employment), and temporary visa status (Bogic et al, 2012). This study (across Germany, Italy and the UK) illustrated post-migration factors accounted for 12.8% of PTSD variance, with trauma accounting for 14.2%. Although, this sample was of former Yugoslavian refugees only, the results suggest the impact of post-migration factors on refugee PTSD should be considered, along with implications of visa status on MH when refugees require support from services.

Momartin, Steel, Coello, Aroche, Silove and Brooks (2006) specifically investigated the implications of visa status amongst Persian speaking refugees in Australia. They found temporary visa status accounted for 68% of the variance of PTSD. A further study by Mueller, Scmidt, Staeheli and Maier (2010) investigated visa status amongst failed asylum-seekers and those with temporary visas. Both groups were found to have significantly high levels of PTSD (~50%). Although, both studies illustrate the effect of visa status on PTSD, the findings should be treated with caution as causality was not fully explored, or time in the host country, which could have impacted on the findings.

Whilst the studies cited above were relatively robust in design, and used valid and reliable measures of PTSD, they did not explore the cultural aspects of PTSD, and the subsequent effect on PTSD presentations. Given the recent debates about the cultural relevance of PTSD, it would seem a more detailed, culturally sensitive understanding of PTSD in the context of post-migration is important. Nevertheless, these studies illustrate the possible significant effects of temporary visa status, and post-migration difficulties on PTSD.

However, within the PTSD literature there seems limited exploration of the losses refugees experience, the importance of these, and the possible impact on PTSD. These losses (which in themselves could be traumatic) may be significant within the complex post-migration difficulties refugees can develop.

## Refugees, Prolonged Grief and Cultural Bereavement

Alongside the experience of PTSD, refugees often report significant familial loss/es occurring before or after arrival in the host country (Eisenbruch, 1990), which can leave refugees in a state of chronic mourning. This may compound feelings of depression associated with the traumatic loss (Miller et al, 2002), PTSD symptoms (Gorst-Unsworth & Goldenberg, 1998), and feelings of guilt (Douglas, 2010). This state of chronic mourning has been conceptualised as prolonged (or complicated) grief (PG – Prigerson et al, 2009).

This concept, although not currently included in the DSM (and with limited empirical refugee research), has been confused with PTSD due to experiences of intrusions (which in PG are largely related to the deceased). However, separation distress allows for differentiation from PTSD (Momartin, Silove, Manicavasagar & Silove, 2004; Lichtenthal, Cruess, & Prigerson, 2004). Morina, Rudari, Bleichhardt and Prigerson (2010) reported the co-morbidity of PG and PTSD, and stated the importance of a contextual and comprehensive assessment before confirming a PTSD diagnosis. Furthermore, PG has been reported to significantly account for the variance of refugees' psychological distress, which suggests links with other MH difficulties and co-morbidity (Craig, Sossou, Schank & Essex, 2008). PG may also add complexity to an intervention for a refugee experiencing PTSD, and possibly contribute to difficulty making adaptations (psychological or otherwise) and moving on with life (Bhugra & Becker, 2005).

Traditional models of grief (e.g. Bowlby, 1980; Parkes & Weiss, 1983) may not suffice to facilitate a deeper understanding of a refugee's traumatic loss to facilitate moving on. It has been proposed traumatic losses leave survivors feeling vulnerable and anxious, which contribute to fracturing of personal meanings (Lifton, 1982), and a shattering of their assumptive world (Janoff-Bulman, 1992). Further, Gillies and Neimeyer (2006) propose complications with resolving loss arise when the survivor struggles to make sense of it within their current context and meaning system, which may be particularly difficult for refugees. Nevertheless, this implies that for relief of PG to be attainable, meaning-making may be important (Currier, Holland & Neimeyer, 2006). However, empirical evidence for this appears limited, and future research which explores how refugees make sense and meaning of their experiences given the losses they have suffered, may provide useful information for therapeutic interventions.

PG coupled with cultural bereavement may further mar the ability to improve refugee psychological health (Craig, Sossou, Schank & Essex, 2008). Cultural bereavement is defined as the grief response to a loss of social structure and cultural values when a migrant moves to a

new country (Eisenbruch, 1990). This concept has received limited focus, but may be useful to further contextualise refugee experiences. Nevertheless, more empirical evidence is required, particularly as loss of culture has been related to increased PTSD (Carswell, Blackburn & Parker, 2011).

Additionally, Eisenbruch (2005) suggested an ideology exists whereby refugees should move from 'horror to hope' (p.107) once arrived in a new country. However, difficulties may occur as this ideal may obscure the refugee's lost home country social structures, politics and values (Eisenbruch, 2005). The literature thus far does not clearly delineate a contextual transition from 'horror to hope', therefore suggesting further exploration is required.

A possible way of moving from 'horror to hope' may be assisting refugees to make sense of their losses. This may facilitate connections with daily living, and thus with resettling into a new country (Eisenbruch, 2005; Bhugra & Becker, 2005). Whilst psychological interventions may assist with improving PG and PTSD, Bhugra & Becker (2005) suggest acculturation may assist the culturally bereaved to move on from grief. However, as outlined in the following section, difficulties with resettlement may contribute to complications with refugees' sense-making and moving on, perhaps more so for those experiencing PG and/or PTSD.

## Refugees, Resettlement and Acculturation

The experiences of PTSD, cultural bereavement and PG may leave refugees feeling significantly distressed. This can often be accompanied by difficulties resettling into a host country and negotiating the host country's culture, which adds complexity to refugee experiences. The resettlement literature, however, is largely theoretical and appears to have limited supporting empirical evidence.

One of the most prominent theories of resettlement is acculturation, (Berry, 1997). Acculturation is defined as the changes an individual makes when they come into contact with 'individuals or groups of a different cultural background' (Sam, 2006, p.11) when residing in a

new country. Berry (1997) described four acculturation strategies; assimilation (preference of the cultural patterns of the host country over the person's own), separation (strong links to the person's own culture and avoidance of the host culture), marginalisation (the person loses contact with both cultures), and integration (a combination of the person's own culture and the host culture). Whilst this model seems a good starting point, it has been criticised for its lack of applicability to refugees as there is limited connection between acculturation strategies and MH (Riedel, Wiesmann & Hannich, 2011).

This also seems to apply to Fullilove's (1996) theory of displacement, which focused on the disruption of attachment, familiarity and identity, and as yet, has not been applied to refugee populations. However, a link between this theory and MH seems apparent, particularly with regard to the 'nostalgia, disorientation, and alienation' (Fullilove, 1996, p1516) migrants may communicate, which refugees could experience. This, alongside loss of home, is purported to be the fundamental commonality of refugees, and core to their difficulties (Papadopoulos, 2002), which may be pertinent to address within psychological interventions.

Conceptualisations of MH and acculturation seem imperative for traumatised refugees. Indeed, Riedel, Wiess & Hannich (2011) proposed a model incorporating sense of coherence (SOC). SOC refers to the development of understanding the world, the ability to manage situations and to make emotional sense of life (Antonovsky, 1987), which the authors suggest may impact on ability to successfully resettle. Sundquist, Bayard-Burfield, Johansson & Johansson (2000) reported SOC may be disrupted upon experiencing trauma, and thus hypothesised traumatised refugees have a weak SOC, making resettlement difficult and increasing psychological distress. However, this study only measured acculturation by assessing capabilities of speaking the host country language. Language may be an important element of acculturation (Birman & Trickett, 2001), but a more holistic method of measuring acculturation may be beneficial for future research.

Of the limited empirical evidence, one UK study qualitatively explored acculturation, stress and integration amongst 138 refugees (Phillimore , 2011). The participants (some of whom spoke English) reported difficulty resettling, feeling unwelcome and experiencing UK society as 'closed'. They also expressed concern about those remaining in their home country, the outcome of their asylum application, and the lack of integration support services. These findings highlighted the potential difficulties of refugee resettlement, but only a minority (n=17) were reported to have a MH diagnosis. This aspect, and English language capabilities, was not further explored in this study.

Previous research reports refugees less able to speak the host country language are more likely to face difficulties participating in the host community, which could contribute to feeling a lack of control and mastery over life (Mansouri & Cauchi, 2006). These feelings, and limited host country language capabilities, may increase distress and PTSD levels (Steel, Momartin, Silove, Coelle, & Aroche, & Tay, 2011; Vojvoda, Weine, McGlashan, Becker, & Southwick, 2008). Therefore, learning the host country language may improve refugee MH, and facilitate better resettlement. Nevertheless, another important aspect of acculturation is identity, which appears limited in the literature thus far.

Padilla and Perez (2003) suggest migration requires the redefinition and reconstruction of personal and social identities. In order to integrate successfully, Padilla and Perez (2003) state one must hold a positive view of identity, be of good MH and 'satisfied' with life. The process of reconstruction suggests refugees should negotiate the personal and social identities brought with them or lost (Bhugra & Becker, 2005), and develop new social identities in the host environment. Possible hindrances to this process could be refugees having inadequate cultural group similarity to identify with (Operario & Fiske, 1999), the experience of stigma (Padilla & Perez, 2003) and cultural bereavement (Eisenbruch, 1990), which may lead to difficulties with viewing themselves positively. Further, personal identity or SOC may be fragmented by the experience of trauma and loss, which could further complicate positive

identity reconstruction (Sutherland & Bryant, 2006; Sundquist, Bayard-Burfield, Johansson & Johansson, 2000).

Traumatised refugees may have to negotiate considerably complex phenomena to successfully resettle. The theoretical base for acculturation is important and useful for those working with refugees. However, more robust empirical investigations are required; specifically, investigations which appropriately measure acculturation processes, and adequately explore refugee SOC and identity reconstruction.

## Refugees and Quality of Life

QoL may be a useful concept to measure refugee experiences as it may incorporate psychological experiences and tangible resettlement difficulties (e.g. housing and employment). QoL is defined as '*a person's perception of his or her position in life in the context of the culture and value systems in which he or she lives*' (De Vries & Van Heck, 1994, p.61), and has been further constructed as an outcome measure to assess treatment benefits (De Geest & Moons, 2000).

Measures of QoL usually include satisfaction with domains of physical and psychological functioning, finances, leisure activities and social support (Moons, Budst & Geet, 2006). More recently, this has included religious, personal and spiritual beliefs, and the importance of each domain (WHOQoL Group, 1993). This broad spectrum can give an indication of how an individual's QoL has been affected by illness/es or MH difficulties, how this changes over time, and the reciprocal interplay between the different domains (Skevington, 2002).

Thus far, low QoL has been widely reported quantitatively amongst refugees, with research illustrating it is related to long asylum procedures (Laban, Komproe, Gernaat & de Jong, 2008), and poor social relations and employment (Carlsson, Olsen, Moretensen, & Kastrup, 2006). Araya, Chotai, Konproe & de Jong (2007) also linked low QoL with mental distress and trauma during displacement. However, this study focussed on internally displaced refugees

rather than those who had fled to a host country, which means generalisations to other refugees should be treated with caution. Additionally, a Swedish QoL study (Ghazinour, Richter & Eisemann, 2004) highlighted a significant relationship between SOC, social support and QoL. However, this study did not take into account PTSD, or further explore causality due to the cross-sectional design. Further exploration of these aspects may be beneficial to develop a clearer understanding of what impacts on QoL.

Within the literature, the relationship between QoL, MH and migration status was highlighted. Nickerson, Steel, Bryant, Brooks and Silove (2011) completed a follow-up quantitative study which investigated the visa status change of Mandean refugees in Australia (from temporary to permanent residency). The authors focused on PTSD and depression symptoms, and QoL. The results showed that change in visa status from Temporary Protection Visa (TPV) to Permanent Residency was significantly associated with lower PTSD and depression symptoms, as well as a higher QoL. This suggests the insecurity of the TPV was detrimental to refugees' MH and QoL. However, this is not definitive as the authors appeared not to take into account the length of time refugees were resident in Australia, which may have affected the findings.

This study seems to follow on from Mueller, Schmdit Staeheli & Maier (2010), and suggests once uncertainty of asylum-seeking has been removed, the refugees' psychological functioning improved (Nickerson, Steel, Bryant, Brooks & Silove, 2011). The authors also suggested change in visa status led to less living difficulties, but this was paradoxically not found in the results. The authors further propose changes in QoL may be due to perceived social support as reported by Araya, Chotai, Komproe & De Jong (2007) and Ghazinour, Ricker & Eisemann (2004). However, Huijts, Kleijn, van Emmerick, Noordhorf and Smith (2012) reported social support seeking as directly affecting QoL, which highlights a possible important difference from the social support reported in previous studies, but this requires further investigation.

In relation to other QoL domains, Stack and Iwasaki (2009) qualitatively explored leisure activities and adaptation of Afghan refugees in Canada. The authors found the collective experience of engaging with friends and family, learning and education, and recreation programmes enabled refugees to engage with the host and their own communities. This consequently built a sense of belonging and purpose, further opportunities, and the capacity to problem-solve (all possibly enhancing resettlement). However, psychological distress was not accounted for, and all refugees had a good grasp of English, which may have significantly contributed to engagement with host community activities (with most participants in education or part-time employment). As such, this shows support for language proficiency being a component of resettlement for refugees, as well as QoL.

QoL measurement could potentially link together the effects of PTSD, loss, cultural bereavement, and resettlement difficulties. However, the concept of refugee QoL requires further investigation as the theoretical guidance is limited, and the WHOQoL (WHOQoL Group, 1993) used in the majority of the studies reported here has not been widely validated in refugee populations (Hollifield et al, 2002; De Vries & Van Heck, 1994). The domains which possibly facilitate improved QoL (such as SS and leisure activities) also require more detailed investigation to enhance our understanding of improving QoL and psychological experiences of traumatised refugees. Increased accuracy and understanding of refugee QoL could provide a more useful and appropriate outcome measure for services and interventions.

## Understanding of the Refugee Experience for PTSD Interventions

Psychological interventions may provide refugees with an opportunity to makes sense of trauma and loss experiences, and improve resettlement difficulties and QoL. Effective psychological interventions for refugees presenting with PTSD are documented, but the evidence base remains limited.

The recommended interventions for PTSD are trauma-focused cognitive behaviour therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR-NICE, 2005). TF-CBT encompasses exposure therapy and cognitive restructuring (Cahill, Rothbaum, Resick & Follette, 2009; Zayfert, DeViva, Becker, Pike, Gillock & Hayes, 2005). Exposure therapy includes in vivo and imaginal exposure, whereby the client is repeatedly exposed to avoided stimuli associated with the trauma, or they relive the traumatic memory repeatedly. These techniques allow habituation to anxiety, leading to less avoidance behaviour. Cognitive restructuring involves identifying, challenging and modifying negative appraisals and beliefs about self, others and the world following the trauma. EMDR utilises bi-lateral stimulation to facilitate the processing of trauma memories and distressing emotions (Shapiro & Maxfield, 2002).

The evidence base for TF-CBT and EMDR may not be entirely applicable to refugees as few participants experienced multiple and severe trauma, which can be characteristic of the refugee experience. As such, reports of refugees remaining symptomatic of PTSD post-treatment may illustrate this, as well as the lack of long-term treatment effects (Palic & Elkit, 2011). This suggests the complex MH difficulties of refugees may require more appropriate intervention.

The development of Narrative Exposure Therapy (NET) has led to some promising outcomes amongst the refugee population (Crumlish & O'Rourke, 2010; McPherson, 2012), with PTSD improvements upheld at follow-up (e.g. Schaal, Elbert & Neuner, 2009), and low dropout rates (Robjant & Fazel, 2010). NET was developed as a culturally sensitive, short term treatment for refugees. It uses principles of CBT and testimony therapy whereby a client constructs a narrative of their life (from birth) to the present, using a timeline to detail positive and traumatic events. The traumatic events are relived for habituation of the emotional response and to reduce the sense of current threat (Schauer, Neuner, & Elbert, 2005; Robjant & Fazel, 2010).

NET represents a shift in psychological interventions of traumatised refugees by developing a narrative which contextualises the traumas in the lifespan (McPherson, 2012), with the possibility for further contextualising within wider systems, politics, losses and identities particular to refugee experiences. The intervention can occur at any stage of the asylum-seeking process as NET therapists believe improved MH is a priority, with which we are better able to meet our basic needs (Schauer, Neuner, & Elbert, 2005). As such, it may accommodate resettlement difficulties and uncertainty more readily than TF-CBT or EMDR.

Whilst it could be suggested psychological interventions facilitate better MH, QoL and resettlement for refugees, this requires further evidence. The theoretical concepts and empirical research in this review may be useful to inform psychological therapy. However, the construction of a clear, holistic, refugee post-migration narrative (Robjant & Fazel, 2010) may be beneficial. This could facilitate improvement or adaptation of therapeutic interventions, and ways to comprehensively meet the psychological and social needs of this population.

## Critique of the Refugee Research

The research cited in this review was largely quantitative, and it has been recommended more formal qualitative psychological research should focus on the lived experiences of refugees (Phillimore, 2011). Qualitative research has few *a priori* assumptions which may enhance understanding of the complexities of refugee post-migration (Khawaia, White, Schweitzer, & Greensalde, 2008), particularly the areas of limited empirical research (e.g. cultural bereavement and acculturation).

Despite the samples of the quantitative research being heterogeneous overall, they seem to highlight the broad difficulties of refugees (possibly within the more homogenous context of disorientation and loss of home). Nonetheless, these difficulties are situated in western constructs, such as PTSD and QoL, which may affect applicability of the findings.

It is also important to acknowledge whether participants were help-seeking (e.g. Carswell, Blackburn &Barker, 2011), which may represent a small minority of refugees able to access services, with some research suggesting help-seeking may be linked with acculturation (Bui, 2003). With this in mind, non-government organisations may have found their niche in bridging the gap between non help-seeking refugees and MH services (e.g. Refugee Radio's Post Traumatic Resilience Project and MIND's campaigns 2009a, 2009b). Consistent formal research from these organisations may be useful to piece together, and track, those who are help-seeking and those not, to perhaps increase the accessibility and suitability of services.

There also seemed limited UK research, which when considering the number of UK refugees who experience MH difficulties, appears to suggest further consideration of this population and their experiences is required. This may further ascertain how the needs of this population may be comprehensively met.

## The Ethno-Cultural Aspects of Asylum-Seeking

It is important to highlight the ethno-cultural aspects of asylum-seeking which appear limited from the literature presented. Specifically, as briefly highlighted earlier, the constructs of PTSD and QoL may not be wholly applicable to this population as they utilise western perspectives. There also seems limited non-western theoretical and empirical research which considers culturally specific, non-western values and beliefs, and their subsequent impact on the constructs of PTSD and QoL.

Further, asylum-seekers' QoL may be significantly affected by less opportunity to socialise with those who hold similar non-western histories, beliefs and values (Bhugra & Becker, 2005). This, alongside the asylum-seekers' differences in cultural perspectives from the western host culture, could impact on their satisfaction with, and perception of, their life circumstances. Additionally, for those from interdependent cultures who have experienced traumatic losses they may experience significant impacts on important social roles. QoL seems

not to acknowledge these factors, or asylum-seekers' previous statuses (e.g. employment), which could further impact on QoL (De Vries & Van Heck, 1994).

Further, with regard to PTSD, it may be worth considering asylum-seeker responses to the uncertainty of asylum-seeking, which could be perceived as further injustice and responded to with anger or despair. This could be particularly relevant when considering hyper-arousal symptoms of PTSD, and asylum-seekers previous experiences of cultural or political injustice or persecution (Silove, 1999). Increasing research which highlights and explores non-western cultural beliefs and values, and how they impact on PTSD and QoL seems imperative to facilitate improving meeting this population's needs.

## Conclusions: What does this mean for Refugees?

It is hoped the theoretical and empirical research presented contributes to further clarity and understanding of refugees' post-migration psychological experiences. From the literature, traumatised refugees are reported to experience significantly high levels of PTSD, which may be exacerbated by adaptation difficulties and the instability of temporary LTR. Further, the traumatic and cultural losses, PG, and difficulty speaking the host country language may further exacerbate mental distress and PTSD. In this context, refugees are hoped to successfully integrate, but this requires attention to the underlying psychological processes of reconstructing personal and social identity, difficulties with sense-making and possible weak SOC. These difficulties may accumulate, and be reflected in, the reported low QoL of refugees, and complex psychological needs of this population.

For refugees to manage better and overcome these difficulties, trauma-focused interventions may help, and could incorporate addressing the needs of reducing PTSD and grief, reconstructing identity, sense-making and strengthening SOC, but this requires further exploration. Furthermore, it seems social support or support seeking could be important in

facilitating QoL improvement. However, further investigation and understanding of this appears limited. Therefore, it may be useful to expand on this in future research.

The literature presented here, attempts to develop a more holistic representation of refugee psychological experiences, but this still appears fragmented with no clear, comprehensive narrative of traumatised refugees' post-migration experiences. A more coherent, ethno-cultural and relational understanding of PTSD, grief, migration processes (e.g. acculturation), and QoL may be helpful for those working with this population to better meet their needs. It also seems apparent further clarification of the concept of QoL for refugees, and which domains are most relevant and how, may be useful to develop valid QoL measurement and enhance interpretation. Further, there appear to be questions regarding how refugees reconstruct identity, and how they make meaning of trauma and loss to move on with life. There may be a role for more qualitative research to explore these areas, which could contribute to further understanding of the underlying psychological processes of refugees' complex needs. This may guide psychological interventions, and assist working towards improving clinical, service and QoL outcomes for traumatised refugees.

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# Section B

# An Exploratory Narrative Study of the Quality of Life (QoL) of Refugees who Experience Post Traumatic Stress Disorder (PTSD)

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**For submission to the Journal of Refugee Studies**

CARLEEN R. SCOTT

## Abstract

Research suggests QoL requires further exploration within the traumatised refugee population. This study aimed to explore QoL in the narratives of refugees with a diagnosis of PTSD, in an attempt to clarify the concept and relevance of QoL. Episodic semi-structured interviews were conducted with seven refugees (5 males, 2 females), which elicited narratives of their experiences since arrival in the UK. Narrative analysis was used; specifically thematic, structural and performance analysis. Main findings included: asylum-seeking involved chronic stress which refugees compared to traumatic home country experiences; and intermittent informal support with meeting basic needs, and containing and consistent formal support from psychological and legal services, were important in developing hope and moving on from stress and suffering. Further, completion of psychological treatment seemed to contribute to the progression of improving other QoL aspects, such as education and employment. Implications of the findings for QoL and interventions are discussed.

**Keywords:** Refugees, Post-traumatic Stress Disorder, Quality of Life, Migration, Social Support

# Introduction

The difficulties of traumatised refugees are reported to be diverse and significant (Stirjk, van Meijel & Gamel, 2011). The intensity of these difficulties may accumulate before, during and after migration, meaning refugees may experience considerable social, medical and mental health (MH) difficulties (e.g. Burnett & Peel, 2001; Gerritsen, Bramsen, Delville, van Willigen, Hovens & van der Ploeg, 2006). Whilst it has been documented refugees require increased access to appropriate services to better meet their psychological and social needs in the UK (Burnett & Peel, 2001; McColl & Johnson, 2006), it seems further contextual understanding of their difficulties to promote progression and MH and QoL improvement is required.

UNHCR (2010) reported the UK hosts 269, 363 refugees and 11,900 asylum-seekers, accounting for 2% of the world's refugee population (Refugee Council, 2011). The UK asylum-seeking process can be complex and lengthy, leaving asylum-seekers, i.e. those awaiting an outcome for Leave to Remain (LTR), in prolonged uncertainty. This may contribute to the reported significant risk of developing MH difficulties (Silove, Steel & Watters, 2000), which can endure after being granted LTR (ergo becoming a refugee). Further, the most prevalent MH difficulties reported for this population are anxiety, depression, and PTSD (Fazel, Wheeler & Danesh, 2005; Murphy, Rojas-Jaimes & Webster, 2002).

## *Refugee Quality of Life*

QoL refers to an individual's subjective perception of their satisfaction or position in life (Moons, Budts & Geest, 2006; World Health Organisation - WHO, 1998). Typical domains measured are physical and psychological functioning, ability to meet basic needs, social support (SS), housing, employment and finances. Although the cultural relevance of QoL was queried, (De Vries & Van Heck, 1994), the WHOQoL (WHO, 1998) was developed with the inclusion of religious and spiritual beliefs to enhance comparability of QoL measurement across cultures (Skevington, 2004).

Research to date reports refugees have a low QoL (Coffey, Kaplan, Sampson, & Tucci, 2010). More specifically, quantitative research has reported low QoL being linked with traumatic exposure (Carlsson, Olsen, Mortensen & Kastrup, 2006), experiences of depression, anxiety and PTSD (Ghazinour, Richter & Eisemann, 2004; Araya, Chotai, Konproe & de Jong, 2007), and a long asylum-seeking process (Laban, Komproe, Gernaaat & de Jong, 2008). Reports of salient QoL domains for refugees are limited, with some research suggesting SS directly impacts on refugee QoL (e.g. Ghazinour, Ricker & Eisemann, 2004). However, this requires further evidence particularly as the cultural validity and theoretical base of refugee QoL is yet to be established, which could facilitate better QoL measurement and interpretation (Hollifield et al, 2002). This seems particularly important as refugee QoL requires positioning within significant losses and trauma, acculturation issues (Riedel, Wiesmann & Hannich, 2011), and cultural value systems (Skevington, 2002) to enhance understanding.

## *Understanding the Refugee Experience*

Refugees may have survived trauma in their home country, and possibly further trauma during migration and post-migration (Kirmayer et al, 2011), potentially leading to significant and chronic traumatisation levels (Palic & Elkit, 2011) and a fragmented self-identity (Crossley, 2000). Refugees are also reported to have suffered significant losses of loved ones (Eisenbruch, 1990), possibly leading to prolonged grief (PG) responses (Prigerson et al, 2009). This, coupled with their loss of home (Papadopoulos, 2002), suggests grief and loss are a significant part of the complex psychological difficulties traumatised refugees experience.

Amongst trauma, identity fragmentation and loss refugees may also experience a weakened sense of coherence (SOC - Antonovsky, 1987), whereby they struggle with understanding their psychological and physical world, and ability to manage. This can further contribute to psychological distress and acculturation difficulties (Sundquist, Bayard-Burfield, Johansson & Johansson, 2000; Riedel, Wiesmann & Hannich, 2011). However, to acculturate successfully (i.e. develop a sense of belonging and integrate– Berry, 1997) in the context of

trauma and loss, may pose significant problems, particularly when the refugee does not speak the resettlement country language (Vojvoda, Weine, McGlashan, Becker, & Southwick, 2008). This adds to the complexity of refugee post-migration. Further, as part of the migration process, they may be required to reconstruct their fragmented identity to promote greater QoL, and good MH (Padilla & Perez, 2003). Whilst resilience could contribute to a shift from the position of a traumatised asylum-seeker/refugee to successful acculturation and reconstructed identity (Schweitzer, Greenslade & Kagee, 2007; Papadopoulos, 2007), a clear contextual narrative of this appears lacking from the literature.

### *The Usefulness of Refugee Narratives*

Constructing narratives is a common human experience across cultures. They contain perceptions and meanings of lived experiences (Atkinson, 2002), and are shaped by our contexts, e.g. culture, gender, race and faith (Morgan, 2000). Further, narratives can assist story-tellers to communicate a sense of self, order and identity from challenging experiences (White, 2004; Murray, 2003).

A PTSD psychological intervention which utilises narrative concepts is Narrative Exposure Therapy (NET - Schauer, Neuner, & Elbert, 2005). This was developed specifically for refugees, whereby a life narrative is constructed to facilitate understanding and meaning-making of traumatic life experiences in the context of social, political and cultural influences. This also allows for the process of bearing witness to traumatic events (White, 2004; Schauer, Neuner, & Elbert, 2005). This understanding and meaning may contribute to reconstruction of the refugee's traumatised and fragmented identity, thus enable them to move on with life (Mansfield, McClean & Lilgendahl, 2010; Padilla & Perez, 2003; Crossley, 2000).

Whilst refugee narratives are recognised and worked with within psychological therapy, the narratives of refugees within formal psychological research appear limited (Skultans, 2004). Narrative inquiry enables researchers to explore the meanings and insights offered for

connections, personal relevance and story-teller identity (Atkinson, 2002; Pavlish, 2007). These explorations can allow experiences to be meaningfully conveyed in ways which enable clinicians to improve lives (Pavlish, 2007).

Refugee narrative research thus far has illustrated refugee experiences are entangled, lack linearity, and include suffering and difficulties related to wellbeing (Kokanovic & Stone, 2010). Further, this research has informed us refugee experiences are not uniform (Eastmond, 2007), and as such few *a priori* assumptions should be made (Phillimore, 2011) to fully investigate their experiences. It could be suggested from this, narrative inquiry may complement quantitative QoL research. The meanings and insights regarding QoL within refugee narratives could enhance our understanding of the concept, and potentially illustrate ways to improve their QoL and psychological wellbeing.

### *Refugee Narratives of Quality of Life*

Few qualitative QoL studies have been documented. One such study by Ekblad, Abazari & Eriksson (1999) explored low QoL amongst refugees. The authors highlighted Iranian refugee patients spoke of similar important areas of QoL compared to Swedish patients, but the narratives contained contrasting content. The Iranian refugees cited social relationships as more holistic, and spoke of empowerment, independence and integration compared to 'fitting in' (p339) reported by the Swedish patients. The authors suggest the contrast may be related to differing socio-cultural contexts, which clinicians should be aware of when assessing and interpreting QoL.

However, this study appeared limited in contextually positioning QoL within experiences of trauma and loss, the transition from asylum-seeker to refugee, and refugee identity and meaning-making of experiences. It seems a broader perspective is required which attempts to elucidate a deepened contextual understanding of the position, relevance and

salient domains of QoL through analysis of refugee narratives. As such, this narrative study proposes to address this, and the research questions posed are:

- How are the experiences of QoL for refugees being treated for PTSD reflected in their narratives?
- Do migration status, QoL, and PTSD each play a role in the narratives of refugees, and if so what is the relationship between them?
- How do refugees go about developing a new identity in their host country in the context of being given a PTSD diagnosis and migration?

Addressing these questions will enable a focus on QoL, particularly the most salient aspects. Further, it is hoped the relationship between PTSD, migration and QoL are narrated, from which areas for future research and possible implications for health and MH service provision can be highlighted. The positioning and role of identity is key to narrative research (Murray, 2003), and may provide indications of how refugees make sense of their experience in the contexts of PTSD and migration, which may be helpful for psychological interventions.

# Method

## *Design*

An exploratory narrative methodology was used to allow for the individual and unique stories of the heterogeneous refugee sample to be considered (Sparkes, 2005). The method also permitted exploration of the common issues across the sample (Sparkes, 2005) in the contexts of their individual sense of self, order, and identity (White, 2004; Murray, 2003).

The development of narratives was deemed important as people construct and internalise stories to express and make meaning of their lives over time (Bruner, 1990). Thus, the narratives could be explored for how the refugees made sense and meaning of their significant life challenges. The use of episodic interviews (Murray, 2003) aimed to encapsulate the narratives of asylum-seeking and being a refugee, which could be analysed to extract the meanings and relationships related to QoL, PTSD and migration in the socio-political context.

## *Ethics*

This study was approved by NHS Ethics and the local NHS research department (Appendix 3), and was carried out according to The British Psychological Society's Code of Ethics and Conduct (2009) and the Health and Social Care Professions Council (2008) Standards of Conduct, Performance and Ethics.

## *Participants*

Purposive sampling was used to recruit participants from an inner London specialist PTSD service. Seven refugees (5 males, 2 females) participated and were aged between 24 and 52. Participants were included if they had a diagnosis of PTSD, and no active psychosis, suicidal ideation, substance misuse, violence or aggression (to reduce risk). See Table 1 for participant demographics. Two participants had children born in the UK, and one participant had children

who were killed in their home country. Five participants were single, two widowed, and all were unemployed.

Table 1.

| **Participant Number** | **Male/Female** | **Trauma Type** | **Length of Time in UK (Yrs)** | **Length of Time Since Granted LTR (Yrs)** | **Interpreter Required (Y/N)** |
|---|---|---|---|---|---|
| 1 | Male | War, Imprisonment | 7 | 3 | Y |
| 2 | Male | War, Imprisonment | 6 | 5 | Y |
| 3 | Male | War, Imprisonment | 11 | 3 | N |
| 4 | Female | War, Trafficking | 2 | 2 | N |
| 5 | Male | War | 11 | 6 | N |
| 6 | Female | War, Rape | 7 | 1 | N |
| 7 | Male | Imprisonment | 7 | 1 | Y |

Countries of origin included Iraq, Afghanistan, and Uganda

## *Apparatus*

A semi-structured interview schedule (Appendix 4) was derived from the literature review, feedback from research supervision, and the university research panel. The questions aimed to elicit the narrative of participants' lives since arrival in the UK, and included their hopes on arrival, difficult or less difficult experiences, life changes since being granted LTR, and hopes for the future. A pilot interview was used to adjust any interview questions.

## *Procedure*

Clinicians at the service were briefed about the study, and provided with the participant information sheet (Appendix 5), and inclusion/exclusion criteria to inform decisions about

eligibility and appropriateness for the study. Clinicians introduced the study to suitable clients and passed on the information sheet. The researcher then contacted these participants by telephone to review the information sheet with them, and answer any questions. If the participant wished to take part, they were invited to the service to complete the consent form (Appendix 6) and commence the interview.

For participants requiring an interpreter, the researcher was invited to meet the participant at the service. With the participant's agreement, the researcher, participant and interpreter met to go through the information sheet together. With the participant and interpreter's consent, the same interpreter was booked for the interview.

Before the interview, the consent form was read and signed, and any final questions from the participants answered. Interviews lasted between 32 minutes and 1 hour and 20 minutes. Following the interview, participants were thanked, and if specific requests were made (e.g. regarding the Home Office or housing), this was referred back to their clinician. The researcher completed a research diary (Appendix 7) to enhance transparency, reflexivity and further inform the analysis.

All interviews were audio-recorded and transcribed word for word prior to analysis. Interviews with experienced and known (to the service) interpreters were carried out according to the service protocols i.e. first person translation (for participant and researcher), and word for word where possible. The transcriptions of interviews with interpreters consisted of the interpreter's and researcher's speech. No funds were available for back-translation.

### *Analysis*

The transcribed data were analysed using a personal narrative framework which incorporated thematic, structural, and performance analysis (Langellier, 1989; Riessman, 2001). These approaches elicited the content, structure, form and performed identity of the participant

within the narratives in the contexts of PTSD, migration and QoL. A form was completed (Appendix 8) for each participant to track and collate the analysis.

Firstly, each transcript was read and re-read carefully, the audio-recording listened to, and notes taken on particular parts of the narratives pertinent to the research questions. Codes were developed for each transcript, which were used to code the narratives, from which themes were developed within cases (see Appendices 9 and 10 for an example of dataset codes and transcript).

For each narrative the overall structure and organization were considered (Murray, 2003; Gergen & Gergen, 1983) to facilitate the exploration of identity, perceptions and values of the narrator (Holloway & Todres, 2005) whilst paying particular attention to PTSD, QoL and migration aspects. The structure and form were conceptualised according to the narrator's evaluative position of progressive, stable or regressive, e.g. an evaluation of life remaining unchanged is a stable narrative, of life worsening or uncontrollable - regressive, and life incrementally improving - progressive (Gergen & Gergen, 1983). This was followed by exploration of the basic forms within the participant's narrative (Gergen & Gergen, 1983) which encompassed the temporality and shifts throughout the narrative between progression, stability and regression, along with the researcher's subjective responses (also informed by the research diary).

Performance analysis was completed to understand each refugee's preferred identity (Riessman, 2001). This preferred identity is selected from a multiplicity of selves at different times over the course of an individual's life rather than as a single unitary self (Riessman, 2001; White, 2004), and takes into account the person's varying contexts. This approach seemed appropriate as it permitted participants' likely varying struggles to make meaning of their experiences (Langellier, 2001; Riessman, 2001).

For each stage of analysis transcripts were analysed individually. The transcripts and individual analyses were revisited, and collated thematically and structurally (Appendix 11) to

facilitate eliciting the common elements. This further illustrated the representations of, and relationships between, PTSD, QoL and migration.

To facilitate credibility of the findings two transcripts with the thematic, structural and performance analysis (individual and collated) were read through by experienced research supervisors. Within research meetings the transcripts and findings were discussed and provided an opportunity for validation checks (Elliot, Fischer & Rennie, 1999), and exploration of believability (Blumenfeld-Jones, 1995; Labov, 1997) and accuracy. Quotes were used in the results to ensure findings were grounded in the data (Elliot, Fischer & Rennie, 1999). Of note, narrative analysis does not stipulate participant feedback, nevertheless, the researcher endeavours to deliver credible and persuasive analysis of the narratives (Riessman, 1993).

# Results

Firstly, an overview of each participant's transcript according to themes, overall structure and performance analysis are presented. Secondly, the cross-case analysis is presented to explore the commonalities of the narratives. The findings are then discussed according to the research questions.

## *Case by Case Analysis*

***Participant One*** was a man in his late thirties. This was a **negative stability** narrative whereby he communicated *living an unhappy life*. There were themes of **suffering,** as he described the asylum-seeking process as 'torture', of **feeling pushed out** by both his family and the UK community, having **no love or support** hence feeling lost and alone in his experience, and **traumatic memories** which seemed entwined with his current experience.

The narrator used his personal history as a cherished, central member of his family, and slow speech, to enunciate his current position of **a sufferer**. This seemed to highlight a current sense of the narrator feeling *ostracised* and *vulnerable*, and the need for him to be protected and cared for.

**Participant Two** was a man in his fifties. This was a **progressive** narrative whereby the evaluative position was *asylum-seeking has finished and I am equal*. The narrator thematically conveyed his experiences of **kindness and acceptance** whilst asylum-seeking, of **not being a liar** despite being judged as such and treated with suspicion. He used his **physical health** to provide concrete examples of how he was treated, and expressed being **blessed** for the luck and positive outcomes that had come his way.

The narrator positioned himself as a **fortunate man**. The considered pace of the narrative and continual expression of balance between positive and negative experiences, positioned him as a *wise man* who had achieved *equality*.

**Participant Three** was a man in his late forties who learned of the death of his family after arrival in the UK. This was a **negative stability** narrative whereby life was *unhappy and tortured*. Themes of **conflict between his expectations and reality** were narrated, whereby he spoke of coming to **'***this country to save my life'* (line 720), but was faced with '*propaganda'* (line 906). He **searched for meaning** through the use of rhetorical and 'why?' questions with no concrete answers, and his **life had remained the same** as he equated life in his home country with the UK.

The narrator's use of staccato speech and repeated citation of lack of human rights and democracy in the UK positioned him as a **frustrated, tortured and unhappy campaigner.** This, alongside the rhetorical questions about his familial losses and current experiences, positioned him as *stuck* in his search for meaning.

**Participant Four** was a woman in her twenties who had one child born in the UK. This was a **progressive** narrative as she narrated having *passed through her difficult experiences*. She communicated the theme of **others had passed through more** than her, both in terms of her short and '*too straightforward'* asylum-seeking process, and the level of trauma she had experienced. She narrated of being **new** and passing through, having let go of her experiences of trauma, PTSD and asylum-seeking.

The narrator positioned herself as **different** to other asylum-seekers. She did not want to be defined by her traumatic experiences, fleetingly narrated difficult moments, and stated she did not discuss her traumas as she wanted to move on. Her use of laughter appeared to illustrate her new found *freedom*, and *aspiration* for her future.

**Participant Five** was a man in his late thirties. This was a slow **progressive** narrative through the narrator's use of temporality. A theme of **passive acceptance** was narrated, whereby there were no strong reactions to the numerous Home Office interviews and following refusals. He spoke of his **'mind story'** whereby his experiences and symptoms of PTSD were

narrated, and a **step by step struggle** was evident through the narrative's structure and narration of becoming stronger.

The narrator positioned himself as **passive** through not questioning his experience, but accepting it. However, this shifted to a position of '*little bit strong'* whereby he felt ready and able to reconnect with his family and face this aspect of his history. The narrative's consistent flow suggested an element of *control* and *renewed agency*.

**Participant Six** was a woman in her twenties who had two children born in the UK. Initially, this was a **negative stability** narrative whereby *life was stressful and difficult.* However, this shifted to **progression** whereby *life was good*. The narrator conveyed themes of life as an asylum-seeker being **'the hardest thing',** of 'my **disorder'** whereby she narrated symptoms of PTSD, which also occurred in the context of seeking asylum and the threat of deportation. She also narrated a **lot of support**, which was consistent and assisted her through the asylum-seeking process.

The narrator initially rapidly shifted between the positions of stressed asylum-seeker and the current position of **good and free**. This suggested she was *torn* between her *lonely asylum-seeker identity* (which appeared linked with her experience as an orphan), and her future hopes and aspirations, which eventually prevailed.

**Participant Seven** was a man in his late thirties, who learned of his wife's death after arrival in the UK. This was a **negative stability** narrative whereby the narrator experienced a *continual struggle*, with a later possibility of progression. Thematically, the narrative contained descriptions and evidence of life in the UK being '**the most difficult period of my life'** (which encompassed asylum-seeking and refugee status). He expressed some commitment (albeit uncertain) to **getting over** his experience, which encompassed PTSD, and the traumas and losses of his past.

This narrative initially positioned the researcher as a member of the host culture, and one of 'them' whom he cannot make understand. This suggested the narrator felt *alienated* and *not understood* by the host culture. The narration seemed used to illustrate the narrator's broken life, and his uncertainty of how to rebuild his **broken self** without his wife.

## *Case by Case Summary*

Overall, the narratives were used in powerful and varied ways to convey experiences, which included aspects of PTSD, QoL and migration. The arising themes and structure differed, but common features were apparent and explored in the cross-case analysis. The narratives illustrated a diverse representation of performed identities which communicated intense experiences.

## *Cross-Case Analysis*

### *Thematic Analysis*

Four cross-case themes were evident from the narratives and are detailed below.

### *1. The Legacy of Seeking Asylum*

This theme consisted of the descriptions of the asylum-seeking process whereby life was repeatedly described as 'stressful', 'difficult', filled with uncertainty, depression and anxiety. Participants readily accessed memories of asylum-seeking and evaluated it as an immensely troubling time, which remained fresh in their minds. There was a tendency amongst the participants to align the experience of asylum-seeking with that of their traumatic experiences in their home countries.

'*...like you leave your country for some trouble and you come here, you come, you're in the same trouble*' (Pp5, line 455-458).

These evaluations of the asylum-seeking process seemed to poignantly endure through the transition to refugee.

'*To this day, and I still think about my life, how it has been, how it is going, and it's still upsetting me more. I am suffered by just thinking about it.'* (Pp1, lines 309-314).

'*When I think about my life, I think the most difficult period of my life is the day I arrived here until...even until now...*' (Pp7, lines 187-189)

Although participants had LTR, a right to work and engage in further education, the legacy of their traumatic experiences and asylum-seeking seemed strikingly at the forefront of their narratives. The descriptions appeared connected to expressions of suffering and difficulty. This may have been exacerbated by participants' expectations of their lives in the UK – '*I come here to save my life'* (Pp3, line 720) and realisation of the reality they were living.

*'The reality and the imagination is like very far away from each other'* (Pp7, lines 179-180).

*'I thought when I arrived in this country, it would be like a rest for me. That was my expectation...I would be free from now on, free, and free from pain, free from suffering, but a different sort of suffering started here...' (Pp1, Lines 392-399)*

The difficulties in attempting to resolve this discrepancy between imagination and reality appeared to contribute to difficulties with understanding and making meaning of their experiences of asylum-seeking and life as a refugee. Interestingly, participants from a similar region expressed this, which may indicate some cultural expectations about life in a western country. For those who did not have clear expectations of life in the UK other than to live a better life, this discrepancy was not apparent. The lack of such expectations may have facilitated being able to move on from the traumatic experiences and being free.

'*When I came, my hope was to find freedom, and I got that.*' (Pp2, lines 473-475)

'*When I got leave to remain, I am free. Yeah I am free and I am OK*. (Pp6, lines 984-987)

These expressions of freedom seemed to underline the end of the asylum-seeking process, and the hardest period of their lives. However, it was also clear being granted LTR did not provide closure to the experience of asylum-seeking.

*'Yeah, the leave to remain, when they came. To be honest, they open another story for me also. It doesn't make everything clear to me. Because it is not clear'.* (Pp5, lines 1277-1282)

***2. Post-Traumatic Stress Disorder***

PTSD within the narratives was expressed initially in terms of the symptoms experienced, such as bad dreams, flashbacks, lack of sleep and some dissociation.

*'I did always think bad dreams, and bad fighting. And like this noise. It never left me'* (Pp5, lines 924-928)

Limited re-telling of past traumatic memories, such as the loss of family members, or friends who were killed was also evident. Some of these experiences, and symptoms, were entwined with the asylum-seeking process, and added to a sense of PTSD (when it was expressed) being uncontrollable or uncontainable.

'*Because even when you sit there, when you are alone, you think a lot – back home through what you've passed through. Then it starts coming out.*' (Pp 6, Lines 228-237)

There were moments in the narratives where PTSD seemed suppressed, and actively so, by the participants for them to manage the practicalities of asylum-seeking, suggestive of asylum-seeking sometimes mediating the experience of PTSD.

*'I put it in some part of my mind. I would try to forget it. Because if I mix it with my situation where I was,..I was...I would have lost my mind'* (Pp5, lines 558-563)

*'I felt so stressed that even being put into prison would be like....like everything was inside...I couldn't keep...bring anything out if I was put to prison...like I would not be relieved.'* (Pp3, lines 128-133)

This expression of PTSD, however, seemed to change when the participants narrated about trauma-focused (TF) psychological therapy.

### *3. Journey to Recovery*

On beginning therapy participants spoke of initial feelings of anxiety and being confronted with time to contemplate and make meaning of their experiences.

*'I was just like...What? Why? Why is this happening? Why am I supposed to go through this just for one person?'* (Pp4, lines 415-420)

Overcoming PTSD was expressed as *'step by step'* or '*little by little'*, with an underlying expression of having the drive to do so.

'*You have to go step by step, because if you didn't clear the first step you are not gonna make the next one* (Pp 5, lines 1201-1203)

*'But I feel like I have the ability to get over this um...problem that I have and rebuild myself again'* (Pp7, lines 252-254)

There were also succinct expressions of commitment to overcoming PTSD, which seemed to encompass narrators' resilience to rebuild their lives and continue psychological therapy - '*I just had to continue'* (Pp4, line 433), '*I have to get to that position'* (Pp5, line 1086), and '*I am going to continue'* (Pp6, line 705). Those who had completed psychological treatment, narrated a sense of closure on traumatic experiences which they had '*passed through'* (Pp 4, line 409, and Pp 6, line 236) with a sense of achievement, enabling them to progress further.

'*I feel like I pass this work now. I move it from my way and I have to keep going'* (Pp5, Lines 1136-1138).

The narrator's communicated a commitment to get on with their lives, get over their experiences and continue on their path with a new purpose.

'*But I don't want to sit down and think about that now. I just wanna move on*' (Pp 4, lines 504-505)

'*I want to feel useful to the country, to myself*. '(Pp2, line 520)

### 4. Importance of Support

The presence of support (or lack of) within the narratives was evident. Initially, it appeared the refugees narrated feeling unsupported and immensely alone, particularly when asylum applications were refused, which resulted in the withdrawal of basic support.

'*I had nowhere. Nowhere to live, nowhere to sleep, nowhere to stay. Nobody could advise me...*' (Pp6, Lines 13-17)

'*You are alone, you don't have any relative, or family or any brother, or any sister, or any father, or mother, or uncle to receive from them the help.*' (Pp3, lines 1086-1094)

This, however, seemed to change once the participants narrated of beginning access to services or acts of kindness by acquaintances and friends. This support appeared later within the context of asylum-seeking, and was characterised by acceptance, consistency and reliability.

*'If for anything I see the GP or doctor, she always show me human part of her more than the professional medical side'* (Pp2, lines 134-136)

'*It's good to be with a very good lawyer [...] Who is very interested in you. In knowing you properly. Who is fighting for you. She or he can do everything to be there'* (Pp6, lines 880-892).

The psychological support expressed appeared to have two functions: a place whereby the traumatic past is listened to, accepted and processed; and the provision of reports which supported the narrators' asylum applications. It seemed these reports demonstrated the narrators were believed and added credence to their experiences.

'*So they don't believe anything unless you give them evidence'* (Pp6, line 385)

*'I asked the doctor to give me a copy of the old report, which she updated, and I gave to them because it was true. I didn't make it up'* (Pp2, lines 315-319)

It was also expressed within this theme how the support narrators received helped to foster and develop hope for their progression.

'*To deal with the whole process even the...anyone who helped me in the smallest way gave me like...like a...hope so I can, you know, I can cope or I'm gonna get there or something'* (Pp7, lines 275-280)

This support seemed to have a significant presence and function within the narratives.

***Structural Analysis***

The narratives fell into two categories; negative stability (n=4) and progressive (n=3). However, common features contributed to the structure of each narrative. The negative stability narratives were characterised by a sense of stuck-ness regarding their experience and identity as one who was stressed and unhappy, and the progressive narratives seemed to evolve from a position of uncertainty and difficulty, to one of being free, independent and purposeful. Other commonalties were evident and explored according to progressive, stability and regressive positions.

***Progression***

Progression occurred within the narratives when feelings of containment and support were expressed (consistent with the *Importance of Support* theme). This appeared to lift the narratives, assisted the narrators to move forward on their journey, and seemed linked with the narrators feeling held in mind, and looked after.

'*I found a lot of friends. It not like strong friends, but to watch your step. I found a lot of people to help me to pass the step. Where I can live for months, for a few months.*' (Pp5, lines 504-508)

Occasions when narrators were provided with a place to stay, food or money (concrete examples of QoL) also appeared to add progression. This seemed linked with expressions of kindness and acceptance, and the creation of connection between others.

*'...he didn't make me feel like a burden on him. He was generous and I stayed with him.'* (Pp2, lines 110-112)

Progression was also linked with access to services (legal, health, mental health, and social), housing, and benefits, particularly after LTR had been granted. Although there was a small hiatus directly after LTR was granted, this shifted to progression once access was re-established. This changed the flow of the narratives, and seemed to add a sense of stability to the narrators' position, which perhaps enabled them to focus on their hopes and aspirations, and thus suggested future progression. The hopes and aspirations expressed largely focussed on work and education (features of QoL). These aspirations seemed stated with a degree of certainty which added a layer of conviction to the progression.

'*Now I want to go to college, and when I finish I probably want to go to uni...and from there, just see what I want to do...*'(Pp4, lines 340-342)

*'I need nursing. I need to put on that uniform.*' (Pp6, lines 547-575)

Furthermore, progression was evident when completion of psychological treatment was narrated. This culminated in the expression of an identity as a free, independent person who had achieved a good outcome (echoing the theme *Journey to Recovery*). Therefore suggesting psychological support was the mediator of being able to achieve this final progressive position of freedom.

***Stability***

The stability moments were characterised by no shifts in evaluative position. They were largely negative and occurred during narration of asylum-seeking, whereby life was difficult, stressful and unhappy. For some, this position did not shift throughout.

'*I did not receive any better care and this country as well...*' (Pp3, **lines, 31-32**)

*'I got seem like physical torture unto my country and I got emotion torture unto this country'* (Pp3, **lines 875-876**)

*'I haven't got any kind of happiness'* (Pp3, **line 1425**)

During the negative stability moments, there appeared a continual evaluation of asylum-seeking being the same as, or the hardest experience they had endured. Furthermore, to enhance the connection between their UK experience and life in their home country, direct comparisons were made, as well as entwining of the past and present. This entwining meant temporality was not used to provide structure, and as such, the traumatic experiences were presented as enmeshed.

'*I still think about my past, what I have been through, what I am going through so...When I was back at home in [REMOVED] and I was imprisoned and tortured, and when I came here I felt like I was tortured as well.*' (Pp1, lines 327-333)

During these parts of the narrative, it struck the researcher how the use of language, repetition of words (which may also be linked with English language abilities), and pace were used to enunciate the experience of suffering and stress, thereby suggesting the negative stability position was quite firmly embedded within their identity.

***Regression***

Regression within the narratives seemed linked with moments of no control or a lack of agency. This was largely in the context of PTSD symptoms, being declined healthcare, searching for meaning, and asylum application refusals.

PTSD was narrated later in most of the narratives, with only Participant One narrating from the beginning about PTSD symptoms, whilst others spoke of the harshness and stress of beginning asylum-seeking. For much of the narratives, the experience of PTSD was suppressed or entwined with the experience of asylum-seeking, and in particular, concerned with the application process outcome.

> '*Every time you wake up your heart is pumping. It's pumping faster, faster. Um...remembering that 'oh that are going to deport me back to be ...ah...to be stressed again'* (Pp6, lines 196-202)

The uncertainty of this time appeared characterised by the shortening of sentences and clauses, and a somewhat quickened pace which added to the sense of despair, isolation and anxiety expressed.

> '*I didn't know the language. I didn't know the laws. I didn't know what to do.*' (Pp7, lines 36-38)

The expression of not knowing seemed connected to not knowing anyone who could help and provide support. The regression seemed starker, and with increased rapidity when the narrator spoke of a refused application and all support being withdrawn.

> *'There is no work. There is no support. Everything become over my head. I couldn't get the money. It was too heavy to...all the news come one times. No support. Nothing.'* (Pp5, lines 172-178)

The brevity of the narration at these times, struck directly to emphasise the overwhelming nature of the asylum-seeking process. Not only in terms of access to amenities, housing and financial support but also the sense of desolation. It seemed unsurprising therefore, PTSD was not apparent at these points of the narration, as much of the focus may have been purely on how to survive. There also appeared a sense of not having a choice about whether to cope with these difficulties.

> *'The coping mechanism is not something that was optional for me. I was forced to and I had to. It was very difficult to cope...'* (Pp7, lines 272-274)

As a researcher this could be interpreted as resilience, however, for the narrators, it seemed there was an external force which propelled them to cope, which added to the sense of a lack of control over their situation.

#### *Structural Analysis Summary*

The analysis illustrated the shifts of regression and stability within the context of being an asylum-seeker was largely linked to PTSD, and the uncertainty and anxiety borne out of asylum-seeking. This seemed to be mediated and transcended by the support offered to and established by the asylum-seeker, which largely consisted of professional support and acquaintances who met their basic human needs. Once support was consistent, the evaluative position of the narrators shifted to progression whereby hope grew, and QoL was developed and stabilised.

### *Exceptions within the Narratives*

The sample for this study was diverse in age and ethnicity, and it is unsurprising there was an exception to the commonalties explored in the analysis thus far.

Participant Four's stark awareness of **difference** was illustrated in the cross-case analysis. This may be linked with her short asylum-seeking process, the type of trauma (trafficking) and resulting pregnancy. It is legislated victims of trafficking are provided with specific support and protection by recognised agencies (Home Office, 2011), and as such their asylum-seeking journey may be contextually different from others. Further, this participant narrated of faith which, at points, carried the narrative and added elements of positive stability. This was strongly connected with her personal history and previous times of difficulty, through which faith had assisted her.

## *How do the Narratives reflect QoL?*

Throughout the narratives QoL appeared to be expressed concretely through access to financial support, housing, and places to stay whilst asylum-seeking. When these needs were met, they appeared to contribute to a sense of hope (albeit for short periods during asylum-seeking).

However, the expression of particular forms of regular SS (particularly legal and psychological), seemed to provide the participants with a consistent base from which they could progress. This support came about when refugees had exhausted all other options and required legal and/or MH support to galvanise their asylum-seeking application, and enhance their well-being. The legal and psychological support seemed to provide space for narrators to be accepted and believed. Thus their experience was given credibility. The reports, in particular, seemed to have symbolic importance, not only in symbolising a secure external base, but in legitimising their stress and difficulties. With SS constructed in this way, it seemed a clear progressive QoL factor in the narratives.

## *What do the Narratives suggest about the Relationship between PTSD, QoL and Migration?*

Migration status appeared at the forefront of the narratives. It seemed to have consistent links with both PTSD and QoL. In particular, migration status (particularly asylum-

seeking) was linked with a lack of support, finances and housing, with PTSD and migration status seemingly entwined in places. Thus suggesting PTSD was present during asylum-seeking, although not explicitly expressed consistently throughout the narratives. Nevertheless, when it was not present, it appeared suppressed, and perhaps only permitted to be expressed when the narrator became engaged in TF therapy.

The relationship between the three concepts explored, appeared dynamic and entangled. The narratives suggested a need for PTSD to be suppressed to begin the asylum-seeking process and to seek a better QoL. However, when QoL was expressed in terms of support when refugees were at their lowest ebb, it seemed to become the springboard for other progressions (including achieving LTR). When support was a strong, consistent presence, this added momentum to the narratives and acted as a mediator of PTSD and other aspects of QoL. The support lifted the narratives, and shifted the evaluative positions and identities of the narrators, perhaps more for those who had completed TF therapy. The more concrete features of QoL, such as housing and benefits (when in place), seemed a representation participants had passed through asylum-seeking, which the support had facilitated.

## *What do the Narratives suggest about the Development of a New Identity?*

The negative stability narratives illustrated the participants being defined by their trauma, and communicated an identity of suffering, torture, being broken or not understood. This negative evaluative position seemed linked with personal history, particularly significant losses, which were part of the traumatic and asylum-seeking experiences. Holding on to these parts of their personal history may have provided them with a way of maintaining their current position, but also prohibited identity reconstruction.

The narrators' identities seemed to signify their position in the narratives, with asylum-seeking a core part of their lived post-migration experiences. However, for the progressive narratives, it seemed psychological support particularly enabled the development (or

reconstruction) of a new identity within the context of PTSD, and migration.  This may have enabled them to express and pursue their hopes and aspirations.

# Discussion

## *Main Findings*

Three main findings were evident from the analysis. Firstly, the narratives were used to communicate a chronic sense of stress and suffering whilst asylum-seeking, which was strikingly compared with traumatic experiences in home countries. Secondly, the stress and suffering appeared to be transcended through intermittent informal support with basic needs followed by consistent formal legal and/or psychological support, which developed hope and progression. Thirdly, personal history, and in particular loss of attachment figures, were important in refugee identity and sense-making of their stressful experiences.

The comparison of the refugees' experiences of asylum-seeking with their home country experiences, struck powerfully within the thematic and structural analysis. The concurrent narration of PTSD and anxiety during the uncertainty of asylum-seeking (e.g. fear of repatriation or homelessness) enhanced the expressions of stress. The fear and anxiety were often accompanied by alienation and disorientation (Fullilove, 1996), and grief regarding loss of home and loved ones (Papadopoulous, 2002), which subsequently culminated in difficulty with making sense of, and managing, their situation (Antonovsky, 1987). The chronic suffering communicated seemed to perpetuate comparisons with home country traumas, which suggested asylum-seeking may contribute to feelings of chronic traumatic stress. The narratives, therefore, qualitatively illustrate previous quantitative findings of asylum-seeking being significantly detrimental to MH (e.g. Laban, Komproe, Gernaaat & de Jong, 2008).

The chronic suffering also coincided with a lack of support. Currently UK policy stipulates asylum-seekers can access limited NHS services, temporary accommodation, and vouchers to obtain food. However, this minimal support can be inconsistent and widely varied leaving asylum-seekers culturally and socially isolated (Bourn, 2005). The scant support narrated also contributed to distress, and was emphasised by the concurrent narration of PTSD.

This fits with previous research which suggests PTSD is most severe when support or social contact is low or absent (Gorst-Unsworth & Goldenberg, 1998; Van Velsen, Gorst-Unsworth, & Turner, 1996; Lie, 2002).

Furthermore, when support *was* expressed it lifted and progressed the narratives, and enabled hope to develop. In particular, the consistent, legal and psychological support appeared to act as a secure external base, which possibly facilitated attachment, a sense of continuity and containment (Papadopoulos, 2002). These formal support relationships were important as they bore witness to the refugees' traumatic experiences which enabled them to be advocated for, believed, and added credence to their experiences (Neuner, Schauer, Roth & Elbert, 2002: White, 2004).

The use of personal history to make sense of the refugees' lives indicated possible difficulties in resolving distress, loss and grief (Gillies and Niemeyer, 2006; Eisenbruch, 2005). Within the narratives, the traumatic experiences and expectations of life in the UK seemed to disrupt SOC (Antonovsky, 1987) and fit poorly with prior personal narratives. However, the progressive narratives appeared to illustrate TF therapy may have enabled sense-making, and reconstruction of identity and SOC, to facilitate further progression, enhance life satisfaction (Padilla & Perez, 2003), and aspire to further QoL improvement.

### *Implications for Quality of Life*

Placing the finding regarding SS in the context of QoL highlights the pertinence of this domain. The support refugees received could be conceptualised as emotional (psychological therapy), informational (help and advice from psychological and legal services) and instrumental (acquaintances who helped with basic needs – Helgeson, 2003). Within wider QoL literature, it has been reported SS increases improve QoL (Helgeson, 2003). However, it has been suggested the type of support required depends on the nature of the stressor (Cutrona, 1990). The findings suggest the consistent informational and emotional support from legal and

psychological professionals matched the refugees' needs for containment, continuity, and being believed; whilst the intermittent support sufficed to meet basic human needs. The use of both culminated in expressions of increased hope, independence and freedom. In this regard, particular attention to SS for refugees appears important for future QoL research, and when assessing the accuracy and interpretation of QoL outcomes (Hollifield et al, 2002).

### *Practical and Clinical Implications*

The UK government has expressed a commitment to meeting asylum-seekers health needs (Department of Health, 2012). The illustration of chronic stress whilst asylum-seeking corroborates the need for this, and the importance of early engagement with appropriate and consistent services to provide legal, social and psychological support (Burnett & Peel, 2001; McColl & Johnson, 2006). Implementation of immediate access to dedicated and knowledgeable refugee services (Burnett & Fasilly, 2002) could provide routine practical and emotional support to facilitate refugees' MH improvement and progression.

Professionals working with this population should consider the importance of consistent relationships, which provide a secure base whereby experiences are bore witness to and progression from chronic stress is established. Further, professionals should also be aware of, and committed to, significant multi-agency working as refugees may require support in several domains including housing, employment, education, and physical health (Burnett & Fasilly, 2002). Additionally, clinical psychology may be in a good position to influence UK policy and practice by increasingly disseminating their experience and research of working with refugees to facilitate improvements in refugee services and practices.

As the analysis illustrated, personal history and loss were a significant way for the refugees to make sense of their experience. Within a psychological intervention, meaning-making may be important to facilitate resolving PG and loss. Dialogues and guided discovery with the dead person/s (Hackman, 2011), or interpersonal psychotherapy techniques focussing

on roles and loss could facilitate this process. These techniques in the context of PTSD have shown promising results (Markowitz, 2010; Bomyea & Lang, 2012), and could be integrated into a TF intervention such as NET. Additionally, a longer intervention may be required due to the chronic suffering within asylum-seeking.

## *Strengths and Limitations*

The analysis allowed for the processing of the narratives' strong emotional content, temporally entwined experiences, and illustrated the key role of personal history and identity in sense-making of the refugees' challenging experiences over time (Kokanovic & Stone, 2010; White, 2004; Murray, 2003). Further, the analysis highlighted and considered individual differences in meaning-making of the refugee experience, thus illustrating important contextual exceptions (Sparkes, 2005; Eastmond, 2007). The findings were also applicable to, and expanded upon, previous findings regarding SS for refugees (e.g. Ghazinour, Richter & Eisemann, 2004).

The refugees' abilities to speak English were not a significant part of the analysis, which could have affected QoL and progression. For interviews with interpreters, back translation was not used; therefore interpretations could not be checked for accuracy. Although narrative research does not stipulate homogeneity (Riessman, 2005), this sample's heterogeneity left culturally specific factors less salient and particular socio-cultural contexts of the narratives were not further explored, potentially impacting on the findings. Finally, more female participants could have facilitated further exploration of their refugee experience.

## *Future Research and Conclusions*

The findings of this study suggest a model of support could be derived for refugees. As such, a future grounded theory study may be appropriate to develop a model which could be tested in future research.

The findings from this small sample are not intended to be generalised, but contribute to the formal psychological research regarding UK refugees. The collective refugee narrative provides further insight into the chronic traumatic stress of asylum-seeking and emphasises the importance of providing consistent, containing and accepting support for progression, and better MH and QoL. Further, it seems explicit attention to grief and mourning within a TF intervention could be beneficial.

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# Section C

# Critical Appraisal

**Word Count: 2000**

CARLEEN R. SCOTT

This paper is a critical appraisal of the Narrative Study in Section B. Four questions are addressed in turn.

***What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?***

This study provided an excellent opportunity to further develop research skills and abilities, learn a new research method, and apply this within a clinical setting.

In deciding to use narrative analysis, I realised the congruence it had with my previous enjoyable clinical experiences of using narrative approaches on my adult and supplementary placement. I hoped this would be applicable to my understanding of the theoretical background of narrative analysis. However, I didn't quite realise how substantial, comprehensive and complex the theoretical background is, and applying this knowledge to the data successfully was an interesting challenge. Nevertheless, the opportunity to develop a good understanding of the theory and methodologies used and immerse myself in the data has enabled me to gain confidence in using the methodology in future.

On further exploring the methodology, I debated which approach would best suit the purpose, and enable the research questions to be adequately addressed. I began to think more creatively about developing an analysis framework which stayed true to the theoretical background and approach. There are no clear guidelines as to the combinations of narrative methodologies (Coffey & Atkinson, 1996), which, although challenging, facilitated me being able to combine the use of thematic, structural and performance analysis. Although this may potentially raise questions regarding reliability, the results indicate the analysis addressed the research questions appropriately.

I particularly looked forward to the research interviews. However, they posed challenges regarding positioning myself as both therapist and researcher, due to concurrently

being on clinical placement at the service. This meant thorough use of the research diary was important, as for one participant in the sample, I became increasingly aware of my prior knowledge of the client, and how this could affect the analysis.

When participants presented as stuck, it was hard to end the interviews. This meant the possibility for the participant and I to be drawn into an unfocused dialogue. However, this may be useful to think of in terms of the narrator communicating being stuck in endless suffering. As the interviews progressed, I became more confident in explaining the parameters of the narrative interview and being in a more contained researcher role. This seemed evident from the later transcripts as more focused narratives were developed with a more definite ending.

From conducting this research and writing the research diary, I believe my reflexivity has been enhanced. I became attuned to, and was able to bracket, my own personal history and relationship with migration, as my parents migrated (separately) from the West Indies in the 1960s. On reflection, this perpetuated my curiosity regarding what helps or hinders migrants to cope with the difficulties they experience. Further, the ideas around sense-making, identity reconstruction, and difference I view as important concepts, which I have returned to throughout my final year of training. This has helped to facilitate my identity sense-making as an ethnic minority and trainee psychologist living and working in majority white areas.

Although I have gained relatively good understanding of some aspects of narrative analysis, I would like to further develop my skills and knowledge in this area. Specifically, this would be the theoretical background, and focussing on individual forms of narrative analysis. In future, I would like to spend more time immersing myself in the context of narrative analysis to deepen and further inform future research.

***If you were able to do this project again, what would you do differently and why?***

The recruitment for the study was quite reliant upon clinicians within the service to identify potential participants. In future, I would spend more time identifying and recruiting participants myself. Therefore, it may have been possible to recruit the recommended eight participants to create a more robust study.

The inclusion of more females in the study may have made for interesting comparison with the male participants, and more representativeness within the sample. It became clear recruiting women was more difficult. In particular, the females within the service who could have been appropriate were either still asylum-seeking, or re-applying for leave to remain (LTR), and so could not be included. However, for the women included in the study, their LTR may have been linked with their children (i.e. their children were classed as British citizens). As both women had children, it could have been interesting to explore how their children had impacted on their QoL, their experience of PTSD, and their identity.

The relatively small sample elicited considerable data, which was, at times, experienced as overwhelming (possibly also linked with learning a new methodological approach). The data appeared laden with concepts and lent itself to several theories not included in the write up, such as further exploration of resilience, post-traumatic growth and possibly Maslow's hierarchy of needs (Maslow, 1954). There seemed insufficient room to consider them all adequately and the complexity of the narratives seemed to contribute to this.

Accordingly, the research supervision was particularly useful and constructive in thinking about theoretical concepts for the write-up. In future, further integration of this process would be useful to add more depth to the research methodology and findings. This may help to clarify useful concepts and also facilitate further reflexivity in processing the complex data.

***<u>Clinically</u>*, *as a consequence of doing this study, would you do anything differently and why?***

The transcribing and analysis itself, was quite an extraordinary experience whereby the transference and counter-transference came alive. At times I felt frustrated, exhausted and despairing, particularly with the negative stability narratives. It seemed the transcripts allowed for further emotional processing of the transference and counter-transference. However, I became aware of how, at the time of the interview, I did not feel these emotions as powerfully. I thought more about the role and potential protection of clinical space and the role of the therapist, and how this can affect transference and counter-transference. The value of these concepts was highlighted for me in this study, and I hope to continue to use them more widely in my clinical work to inform and use within the therapeutic relationship.

Whilst listening back to the interviews, and transcribing them, it also gave me the opportunity to improve my research interview skills, and become aware of particular nuances in my speech, which could be adapted to improve my communication. As such, I became interested in increasing my use of audio-recording in clinical sessions. The usefulness of audio-recording therapy/clinical sessions may be a valuable tool for me to use within my own practice and supervision, to assist with honing my clinical skills and the emotional processing of complex work.

Through the process of analysis, I became acutely attuned to the participant's use of personal history to make sense of life. The tools for narrative analysis could further inform future clinical practice, particularly when thinking about how clients communicate their difficulties, and the changing positioning of myself and the client throughout sessions and therapy. It also seems important for me to keep in mind the power of *a priori* assumptions, and striking the balance between clients' lived experiences, theoretical knowledge, and the practical application of theory. This may assist in developing formulations which clients can have a

deeper connection with, and thus create a more grounded, shared understanding of their presenting difficulties.

Conducting this research enabled me to connect with the emotional profoundness of asylum-seeking and the importance of appropriate support which facilitated QoL and mental health improvements. Whilst the UK is a signatory of the Refugee Convention (1951 – United Nations, 2012), which is central to the international protection of refugees; the comparisons of UK asylum-seeking with traumas experienced in home countries were saddening. Nevertheless, the narration of uncertainty and chronic difficulties during and after asylum-seeking made this comparison understandable.

Placing the research findings within the current socio-political context validates the imperative need for the implementation of consistent professional support, particularly with asylum applications rising (UNCHR, 2011). In the UK, regular nationwide dispersal of asylum-seekers means isolation levels, geographical location and consistent access to culturally appropriate resources can be widely varied (Atfield & Brahmbhatt & O'Toole, 2007). Additionally, the government's budget cuts have led to reductions and closures of refugee organisations (Hill, 2011). Although there have been increases in innovative support for this population (Gill, 2012), a shortfall in access to consistent, culturally appropriate, professional support remains. Furthermore, once refugees are granted LTR this is typically limited leave of five years, meaning life can remain unsettled (Refugee Council, 2010). This context suggests support for this population should be culturally appropriate, geographically consistent and ongoing.

This research, and its socio-political context, has compounded my commitment to advocate for, and work with, refugees and asylum-seekers in a voluntary or paid capacity. Within my practice I would like to facilitate shared understandings of this population's

difficulties in an attempt to enhance better meeting their needs. I would also like to further contribute to formal psychological research, and remain committed to encouraging implementation of better services for this population which can facilitate alleviating distress during asylum-seeking.

***If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?***

Following completion of the study, I had two ideas for potential projects: one qualitative and one quantitative.

Firstly, it struck me how limited personal history details within the current study's narratives and the narrator's expectations were strongly communicated, and how this assisted them to make sense of their current experience. The life stories of refugees may facilitate further development of ideas about identity, provide scope to explore expectations, and how refugees make sense and meaning of life. As such, a life narrative study could address the research question of: How do traumatised refugees use their personal history to make sense and meaning of their experiences? It may be interesting to focus on a specific country of origin, or perhaps on one or two participants to allow for comprehensive exploration of the complex life stories developed. The life narratives may provide further scope for the inclusion, refinement, and development of more detailed psychological theory to provide a deeper understanding of the participants' lived experiences, and further inform psychological and/or or social interventions.

Secondly, following the hypothesis of trauma-focused (TF) therapy potentially affecting the reconstruction of identity and meaning-making it may be interesting to explore a potential link between a sense of coherence (SOC) and completion of TF therapy. SOC is connected with mental health, identity and meaning-making as it explores how people make sense of their

experiences of adversity, whether their personal resources can meet demand, and whether the person believes the challenges they face are worth engaging with (Eriksson & Lindström, 2006). The hypothesis would be that refugees who have experienced trauma may experience a shattered sense of self, and thus would perceive themselves and the world incoherently (Crossley, 2000). Piecing this with the possibility of SOC improvement from completing TF therapy, could therefore present the research questions of: Does TF therapy affect SOC amongst refugees with a diagnosis of PTSD? If so, what are the effects, and which domains are most affected?

The design could be a repeated measures whereby participants could complete a pre and post, and follow-up treatment measure of sense of coherence (e.g. Antonovsky, 1993), along with a symptom severity measure for PTSD such as the Impact of Events Scale – Revised (IES-R – Weiss & Marmar, 1997). The SOC measure has been used in diverse cultural contexts, and been shown to have good reliability and validity (Eriksson & Lindström, 2006). Further descriptive data of the sample regarding depression and anxiety could be used to investigate correlations between depression, anxiety and SOC. This may assist with highlighting what contributes to the longevity of treatment effects, i.e. whether high SOC contribute to long term reduced PTSD, depression and anxiety symptoms.

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# Section D

# Appendices

## Appendix One – Search Terms

| **Search Terms** | **Databases (Relevant Papers in brackets)** | | | | **Total Relevant Papers (Excluding duplicates across databases)** |
|---|---|---|---|---|---|
| | CINAHL (Ebsco) | PsycINFO | Web of Knowledge | MEDLINE | |
| Refugees AND asylum seekers AND PTSD | 7 (3) | 64 (10) | 77 (20) | 32 (10) | 18 |
| Refugees AND PTSD AND identity | 0 | 17 (1) | 1 (1) | 3 (1) | 1 |
| Asylum seekers AND PTSD AND Identity | 0 | 0 | 1 (1) | 0 (0) | 1 |
| Refugees AND asylum seekers AND PTSD AND treatment | 2 (1) | 27 (4) | 25 (7) | 8 (4) | 6 |
| Cultural bereavement AND refugees | 1 | 8 (3) | 18 (4) | 5 (3) | 4 |
| Cultural bereavement AND asylum seekers | 0 | 0 | 1 (1) | 0 | 1 |
| Prolonged grief AND refugees | 0 | 0 | 4 (2) | 0 | 2 |
| Prolonged grief AND asylum seekers | 0 | 0 | 0 | 0 | 0 |
| Complicated grief AND refugees | 0 | 4 (4) | 10 | 3 (2) | 4 |
| Complicated grief AND asylum seekers | 0 | 0 | 0 | 0 | 0 |
| Refugees AND resettlement AND PTSD | 4 (1) | 44 (3) | 34(1) | 20 (5) | 5 |
| Asylum seekers AND resettlement AND | 2 (1) | 4 (1) | 7 (2) | 2 (1) | 2 |

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| PTSD | | | | | |
| Refugees AND acculturation AND PTSD | 1 (1) | 4 (1) | 20 (1) | 3 (1) | 1 |
| Asylum seekers AND acculturation AND PTSD | 1 (1) | 4 (1) | 2 (1) | 3 (1) | 1 |
| Refugees AND acculturation AND identity AND PTSD | 0 | 0 | 1 (0) | 0 | 0 |
| Asylum seekers AND acculturation AND identity AND PTSD | 0 | 0 | 0 | 0 | 0 |
| Refugees AND acculturation AND identity | 2 (0) | 87 (2) | 70 (1) | 26 (1) | 2 |
| Asylum seekers AND acculturation AND identity | 0 | 6 (0) | 2 (0) | 1 (0) | 0 |
| Refugees AND quality of life AND acculturation | 0 | 6 (1) | 30(5) | 7(2) | 8 |
| Refugees AND quality of life AND resettlement | 1 (0) | 7 (0) | 13 (2) | 1 (0) | 2 |
| Refugees AND quality of life AND PTSD | 2 (1) | 16 (5) | 30 (4) | 14 (5) | 6 |
| Asylum seekers AND quality of life AND PTSD | 1 (1) | 2 (2) | 9 (4) | 2 (2) | 4 |
| Asylum seekers AND quality of life AND acculturation | 0 | 1 (0) | 0 | 1 (1) | 1 |
| **Total Relevant Papers (Excluding Duplicates Across Searches)** | | | | | **36** |

* Titles, abstracts and keywords were searched with no time limit

Identified papers were manually searched for references which may be applicable, and to provide evidence by which to critique and further discuss the research and theoretical findings. Google was used to search for additional references from NGOs presented in the review.

## Appendix Two – Table of Selected Papers

**Summary Table of Empirical Papers**

| **Section** | | | | | | |
|---|---|---|---|---|---|---|
| **Author** | **Aim** | **Country** | **Sample Details** | **Measures and Analysis** | **Results** | **Brief Strengths and Limitations** |
| Bogic et al. (2012) | To test whether similar socio-demographic factors and post-migration stressors are associated with PTSD | Germany<br><br>Italy<br><br>UK | Sample size n=854 (≥255 per country)<br><br>Mean age = 41.6<br><br>Males = 416<br><br>Females = 438 | • Mini International Neuropsychiatric Interview (Sheehan et al, 1998)<br>• Life Stressor Checklist (Wolfe & Kimerling, 1997)<br>• Post-migration stressors e.g. separation from family, finances recorded on a Likert Scale<br>• Demographics collected via brief questionnaire<br><br>• Multivariate logistic regression | • PTSD associated with more traumatic experiences ($p<0.001$), more migration-related stress ($p=0.002$), and temporary residents permit $p=0.005$) | • All interviewers bilingual<br>• Large sample to allow comparisons<br>• Snowball sampling and variations in recruitment across the countries may have affected representativeness of the sample<br>• Assessment of post-migration stressors not reportedly standardised or |

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| | | | | | | validated |
| Carswell, Blackburn & Barker (2011) | Investigated the relationship between trauma, post-migration problems, social support and mental health | UK | Refugees and asylum seekers = n=47<br><br>Mean age = 38.4<br><br>Males = 27<br><br>Females = 20 | • Demographic and Post-Migration Living Difficulty Questionnaire (Steel et al, 1999)<br>• Adapted Short Form Social Support (Sarason et al, 1987)<br>• Harvard Trauma Questionnaire (Mollica et al 1992)<br>• Hopkins Symptom Checklist-25( Parloff et al, 1954)<br><br>• Bivariate relationships (with Bonferrroni correction to control for Type 1 error) | • Bivariate associations between increased symptoms and number of traumas, adaptation difficulties (p=0.003), loss of culture and support(p=0.006) | • HTQ & HSC-25 has adequate psychometric properties amongst different cultures and ethnic groups<br>• Short Form Social Support Questionnaire adapted but validity of change not tested, and may not have captured full experiences of social support<br>• Heterogeneous sample of help-seeking refugees and asylum-seekers only |
| Jobson & O'Kearney (2008) | Investigated the cultural differences in | Australia | Trauma survivors from interdependent | • Post Traumatic Stress Disorder scale (Foa, Riggs, Dancu & Rothbaum, 1993) | • No differences in PTSD scores<br>• Trauma survivors | • All measures had good test-retest reliability |

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| | self-defining memories and self cognitions in those with and without PTSD | | cultures with PTSD n=26 (mean age = 41.15, males =6)<br><br>Independent cultures with PTSD n=24 (mean age = 34.25, males =9)<br><br>Control groups for both without PTSD n=56 | • Trauma History Questionnaire (Green, 1996)<br>• Twenty Statement Test (Kuhn & McPartland, 1954)<br><br>• ANCOVA | from independent countries reported more self-defining memories (p<.05) and self cognitions related to trauma (p<.01) than those from interdependent cultures | and concurrent validity<br>• Heterogeneous and largely female sample<br>• Although included migrants and refugees, unclear of further demographics |
| Laban, Gernaat, Komproe, Schreuders & De Jong (2004) | To investigate the impact of long asylum-seeking process on the prevalence of mental disorders | The Netherlands | Two groups of Iraqi asylum-seekers:<br><br>Residing in Netherlands for less than 6 months n=143<br><br>Residing in Netherlands for more than 2 | • WHO Composite International Diagnostic Interview (WHO, 1997)<br>• Harvard Trauma Questionnaire (Mollica et al, 1987)<br><br>• Univariate logistic regression | • Prevalence of 42% for group who resided less than 6 months and 66.2% for those who resided more than 2 years<br>• Post-migration risk factors identified included length of asylum process, socio-economic | • Culturally validated and translated measures<br>• High number of participants who were non-contactable and so representativeness of sample could be |

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| | | | years n=151<br><br>Age:<br><br>– 18-24 = 15.3%<br>– 25-34 =45.6%<br>– 35-44 =20.4%<br>– 45-64 =13.6%<br>– >64 =5.1%<br><br>Males = 64.6%<br><br>Females =35.4% | | status, and lack of social support | questioned<br>• All interviewers fluent in Dutch and Arabic and trained by WHO |
| Momartin, Steel, Coello, Aroche, Silove & Brooks (2006) | To investigate the impact of temporary versus permanent protection visas for refugees | Australia | Persian speaking refugees with temporary visa n=49<br><br>Persian speaking refuges with permanent visas n=67<br><br>Mean age = 37<br><br>Males = 61 | • Harvard Trauma Questionnaire (Mollica et al 1992)<br>• Hopkins Symptom Checklist (Mollica et al, 1987)<br>• General Health Questionnaire (Goldberg & Williams, 1988)<br>• Medical Outcomes Study Short Form (Gandek et al, 1998)<br>• Post-migration Living | • Temporary visa status strong predictor of PTSD (accounting for 68% of the variance)<br>• Temporary visa status also associated with ongoing living difficulties which contributed to psychiatric | • Measures were translated and back-translated<br>• No details of country of origin, and no account or discussion of cultural differences<br>• Potential sampling bias as some of the |

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| | | | Females = 55 | Difficulties Checklist (Silove, Sinnerbrink,Field,Manicav-asagar, & Steel,1997; Silove, Steel, McGorry, & Mohan, 1998).<br>• Multiple linear regression | outcome | permanent visa holders were sponsored, which meant they had received more family and social support than those non-sponsored |
| Mueller, Schmidt, Staeheli & Maier (2011) | Comparison of the mental health of failed asylum seekers with asylum-seekers (FAS) with temporary visa (TV) | Switzerland | FAS n=40<br>Mean age = 32.10<br>Males = 38<br>Females =2<br>TV n= 40<br>Mean age = 32.10<br>Males = 38<br>Females =2<br>Participants matched for age, gender, years of education and | • Harvard Trauma Questionnaire (Mollica et al, 2004)<br>• Posttraumatic Diagnostic Scale (Foa, Cashman, Jaycox & Perry , 1997)<br>• Hopkins Symptoms Checklist-25 (Parloff et al, 1954)<br>• Paired sample t-tests<br>• Wilcoxon tests for paired samples | • Both groups severely affected by PTSD – whole sample of 'moderate' severity<br>• PTSD rates ~50%<br>• Samples did not differ regarding, PTSD, depression or anxiety | • Good matched sample<br>• Heterogeneous sample derived from 18 countries<br>• PDS and HTQ have good reliability and validity<br>• Self report rather than clinician rated/diagnostic interview scales a potential limitation<br>• Cross-sectional design, |

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| | | | number of traumas<br><br>Cohen's effect size d=.34<br><br>Average duration in Switzerland 5.8 years | | | therefore cannot explore causality<br>• Limited female sample |
| **Section: Refugees Prolonged, Grief and Cultural Bereavement** | | | | | | |
| **Authors** | **Aim** | **Country** | **Sample Details** | **Measures and Analysis** | **Results** | **Brief Strengths and Limitations** |
| Craig, Sossou, Schank & Essex (2008) | Investigation of mental health and wellbeing in Bosnian refugees | USA | Random sample n=126<br><br>Mean period living in USA = 9 years<br><br>Mean age = 42<br><br>Males = 44%<br><br>Females =56% | • Traumatic Life Events Questionnaire (Kubany, 2004)<br>• PTSD Screening and Diagnostic Scale (Kubany, 2004)<br>• Inventory of Complicated Grief (Prigerson et al 1995)<br>• Mental Health Inventory (Viet & Ware, 1983)<br><br>• Sequential Regression | • Traumatic grief accounted for 31% of variance in general mental health<br>• PTSD added 6% to this figure | • A small amount of missing data, therefore possibility of distortion<br>• Limited generalisation to other refugee populations<br>• Social support and receipt of treatment not considered as variables |

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| Momartin, Silove, Manicavasag-ar & Steel (2004) | Explored the antecedents of grief and the relationship to PTSD | Australia | Bosnian Muslim refugees n=126<br><br>Mean age = 47<br><br>Males = 49<br><br>Females =77 | • Clinician Administered PTSD Scale (Blake et al, 1995)<br>• Structured Clinical Interview for the DSM IV (SCID – First, Spitzer, Gibbon, Williams, 1997)<br>• Core Bereavement Items (Burnett, Middleton, Raphael, Martineck, 1997)<br><br>• Logistic Regression | • PTSD rate = 63%<br>• Traumatic loss consistent predictor of complicated grief<br>• PTSD unrelated to grief<br>• Complicated grief intrusions connected with the lost person, and distress when thinking about the deceased | • Non-random selection of sample which yielded high levels of psychopatholo-gy<br>• Use of an interpreter, but not stated what model/method of interpretation used<br>• Measures translated but appeared to capture construct of grief well.<br>• No control group |
| Morina, Rudair, Bleichardt & Prigerson (2010) | Diagnostic concordance of prolonged grief disorder (PGD), major depressive disorder and | Kosovo | N=60<br><br>Mean age 40.6 years<br><br>All had family members killed in | • Inventory of Complicated Grief-Revised (Prigerson & Jacobs, in press)<br>• MINI International Neuropsychiatric Interview (MINI; Sheehan et al., 1998; Albanian version: Morina, 2006) | • PGD related to sleeping difficulties, major depressive disorder, anxiety and embitterment<br>• 65.2% of those with PGD met | • Interviews were conducted in Albanian<br>• ICG proven reliable and valid<br>• Findings highlight |

| | PTSD | | Kosovar war<br><br>Males=20<br><br>Females=40 | • Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997; Albanian version: Morina, Böhme, Morina, & Asmundson, submitted).<br>• Harvard Trauma Questionnaire (Mollica et al, 1992)<br><br>• Multivariate logistic regression | criteria for PTSD<br>• Those with PTSD (48.6%) did not meet criteria for PGD | distinction between PTSD and PGD<br>• Mostly female sample<br>• Cross-sectional design therefore limited exploration of causality |
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| **Section: Refugees Resettlement and Acculturation** | | | | | | |
| **Author** | **Aim** | **Country** | **Sample** | **Measures and Analysis** | **Results** | **Brief Strengths and Limitations** |
| Phillimore (2011) | Exploration of the different factors which influence acculturation and how these factors impact on ability to integrate | UK | Refugees n=138<br><br>20 different countries of origin<br><br>Age range = 17-55<br><br>Females =36%<br><br>Males=64% | • Interviews in mother tongue or English which explored metal health problems, settlement experiences and what impacted on integration<br><br>• Thematic analysis | • High levels of isolation<br>• Feeling displaced and unsettled impacted on ability to settle<br>• Anxiety of asylum process impacted on ability to settle<br>• Refugees became separated or marginalised | • Interesting and detailed study exploring acculturation<br>• Full demographics of sample not provided, including details of mental health diagnoses<br>• Language not fully explored |

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| | | | | | | with regard to acculturation<br>• Interpreting or transcription of interviews not mentioned<br>• Method of analysis and credibility checks very brief therefore reliability and credibility could be questioned |
| Steel, Momartin, Silove, Coelle & Aroche & Tay (2011) | Investigation of differences in the trajectory of psychological symptoms and social adaptation | Australia | Refugees from Afghanistan and Iran n= 104<br><br>(86% Afghanistan, and 14% Iran)<br><br>Temporary visa status (TPV) and Permanent Visa (PV) status | • Harvard Trauma Questionnaire (Mollica et al 1992)<br>• Hopkins Symptom Checklist – 25 (Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987)<br>• General Health Questionnaire (Goldberg & Williams, 1988)<br>• Post Migration Living Difficulties Checklist (Silove, Sinnerbrink, Field, Manicavasagar, & Steel,1997; Silove, Steel, | • TPV refugees data suggests increasing mental distress ($p<0.001$), social isolation, difficulty with acculturation, and no language proficiency improvement ($p<0.001$) over time<br>• PV showed improvement over time | • Measures were translated and back-translated although not validated<br>• Longitudinal over two years<br>• Limited sample size and sample predominantly Afghani, therefore caution needed for generalisation |

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| | | | Followed up after two years<br><br>Mean age = 36<br><br>Males = 59<br><br>Females =45 | McGorry, & Mohan, 1998).<br><br>• ANCOVA | | • Did not assess mental health service use and impact of this on findings |
| Sundquist, Bayard-Burfield, Johansson & Johansson (2000) | To investigate whether exposure to violence, low sense of coherence, poor acculturation, lack of control, were associated with psychological distress | Sweden | Refugees n=1980 (921 = male; 1059= female)<br><br>Countries of origin Chile, Iran, Turkey and Poland<br><br>Age range 27-60 | • General Health Questionnaire (Goldberg, 1972)<br>• Sense of coherence measures using three questions from short version of SOC (Lundberg and Nyström, 1995)<br>• Acculturation measures using Swedish language<br><br>• Unconditional logistic regression | • Low SOC significantly predicted psychological distress in men and women after adjustment for age (not reported in table)<br>• Poor sense of control and poor Swedish language abilities (men only) linked with increased psychological distress | • Large sample<br>• Professionally trained interpreter used for completion of measures<br>• Only three items of SOC measure used with no rationale or discussion of effect on validity and/or reliability<br>• Acculturation not adequately measured (only by ability to speak Swedish language) |

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| Vojvoda, Weine, McGlashan, Becker & Southwick (2008) | Prospective evolution of trauma-related symptoms after 3.5 years of resettlement | USA | Bosnian refugees: initial evaluation n=45, after 1 year n=34, after 3.5 years n=21<br><br>Age range at baseline = 13-55<br><br>Males = 12<br><br>Females =9 | • PTSD Symptom Scale (Foa, Riggs, Dancu & Rothbaum, 1993)<br>• Global Assessment of Functioning (GAF – American Psychiatric Association, 1987)<br>• Symptom Checklist-90-Revised (Derogatis, 1983)<br>• Communal Traumatic Experiences Inventory (Weine et al, 1995)<br>• English proficiency questionnaire from resettled refugee's instrument (Westermeyer, & Her, 1996)<br><br>• Hierarchical Regression | • English proficiency added marginally to predicted PTSD severity(p<0.10)<br>• English proficiency significantly increased (p<0.01)prediction of GAF<br>• After 3.5 years 24% of sample met criteria for PTSD | • Small sample<br>• Limited generalisation<br>• Full version of resettled refugees instrument not used and no rationale for this or validation reported<br>• All measures translated and back-translated although validation not reported |
| **Section: Refugees and Quality of Life (QoL)** | | | | | | |
| Araya, Chotai, Komproe & De Jong (2007) | To investigate the pathways underlying the relationship between trauma, mental distress and | Ethiopia | Sample of 1193 adult Ethiopian refugees internally displaced within | • Harvard Trauma Questionnaire (Mollica et al., 1992)<br>• Symptom Check List (Derogatis & Cleary, 1977)<br>• WHOQoL BREF | • Mental distress significantly negatively correlated with QoL<br>• Mental distress a mediator for | • All measures translated into Ethiopian, and culturally validated and translated<br>• Detected |

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| | QoL | | Ethiopia<br><br>Reported in previous unpublished study | (WHOQoL Group, 1998)<br>• Social Provisions Scale (Cutrona & Russell, 1987)<br><br>• Structural Equations Modelling | effects of trauma on QoL (p<0.001)<br>• Trauma during displacement decreased QoL (p<0.001)<br>• Social support not associated with mental distress, but associated with higher QoL | conceptual difference between psychological domain of WHOQoL and Symptom Checklist<br>• Self report measures used rather than diagnostic interviews<br>• Correlations were medium (0.3-0.5). Cannot explore causality further<br>• Refugees were internally displaced which may make generalisations to externally displaced refugees cautionary. |
| Carlsson, Olsen, Moretensen | To investigate long term changes in | Denmark | Refugees n=139 | • Hopkins Symptom Checklist-25 (Mollica et al, 1987) | • Significant improvement in symptom scores, | • Translation and back-translation of questionnaire- |

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| & Kastrup (2006) | symptoms of PTSD, depression, anxiety and QoL 10 years after admission to a specialist service | | Mean age – 44.7 years<br><br>63% follow-up rate of those initially assessed 10 years previously<br><br>Initial data collection 1991-1994<br><br>Follow up data collection 2002-2003<br><br>Males = 126<br><br>Females = 13 | • Hamilton Depression Scale (Becj et al, 1986)<br>• Harvard Trauma Questionnaire (Mollica et al., 1992)<br>• WHOQoL-BREF (WHOQoL Group, 1998)<br><br>• Paired T tests<br>• Multiple linear regression | but remained symptomatic<br>• Poor social relations (with family or friends) and unemployment predicted low QoL (p<0.05)<br>• Longer stay in Denmark predicted higher scores on mental and environmental domains (p<0.05) | es, use of bilingual psychologist for data collection and interpreter if needed<br>• All countries of origin not reported and cultural impact on QoL not discussed<br>• Only Muslim religion was reported and this domain of QoL was not explored more fully in the analysis<br>• Largely male sample |
| Ghazinour, Ricker & Eisemann (2004) | To investigate the relationship between SOC, coping and social support and QoL | Sweden | Convenience sample of 100 Iranian refugees<br><br>(Mean age 38.41 – males; 35.71 – females) | • WHOQoL -100 (WHOQOL Group, 1995)<br>• Sense of Coherence Scale (Antonovsky, 1987)<br>• Interview Schedule of Social Interation (Duncan-Jones, 1978)<br>• Symptom Checklist - SCL-90 (Derogatis & Cleary, 1977) | • SOC, coping resources and social support closely related to QoL (p=0.001)<br>• QoL, social support and coping resources related to psychopathology | • Cross sectional design means causality cannot be further discussed<br>• Correlations also do not provide evidence of causality<br>• Quite |

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| | | | | • T tests and Pearson Correlations | | homogenous sample - majority experienced war in Iran or Iraq, and depression<br>• No inclusion of a PTSD measure/severity despite trauma history of participants |
| Huijts, Kleijn, van Emmerik, Noordhof & Smith (2012) | To compare goodness of fit indices of whether coping style affects QoL via PTSD or whether PTSD affects QoL via coping style | Netherlands | N=335 refugees referred to specialist service<br><br>Mean age =41.9<br><br>Male =251<br><br>Females=84<br><br>Participants from 38 different countries | • COPE EASY-32 (Kleijn, VanHeck & Van Waning, 2000)<br>• Adapted COPE inventory (Carver et al, 1989)<br>• Harvard Trauma Questionnaire (Mollica et al., 1992)<br>• WHOQoL BREF (WHOQoL Group, 1998)<br><br>• Path analyses | • Participants reported severe PTSD and low QoL<br>• However, hypothesised models did not reflect data well enough<br>• PTSD ($p<0.001$), social support seeking ($p<0.001$), and emotion focused coping ($p<0.001$)directly affected QoL | • Cross-sectional design and therefore limited exploration of causality<br>• Translations of measures were not validated<br>• Self report measures used rather than diagnostic interviews<br>• Language and cultural differences on data cannot be ruled out. |

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| Laban, Komproe, Gernaat & De Jong (2008) | To explore QoL, disability and physical health and the relationship with psychopathology amongst Iraqi refugees | Netherlands | Group 1 (less than 6 months in Netherlands) n=143 (males = 49.7%, females = 50.3%)<br><br>Group 2 (living in the Netherlands for at least 2 years) n=151 (males = 78.8%, females = 21.2%)<br><br>Age range = 18-64 | • Harvard Trauma Questionnaire (Mollica et al., 1992).<br>• Psychiatric disorders assessed using the World Health Organisation Composite International Diagnostic Interview (WHO, 1997)<br>• WHOQoL-BREF (WHOQoL Group, 1998)<br><br>• Multivariate regression | • Iraqi asylum seekers who stayed more than two years had significantly lower QoL than those who arrived less than 6 months ($p<0.0005$)<br>• Length of asylum process linked with lower QoL ($p<0.05$) and lower physical health ($p=0.001$) | • WHOQoL-BREF has good psychometric properties with cross-cultural validity<br>• Longitudinal study would be a preferable design<br>• Cross sectional design cannot give evidence for causality<br>• Took into account religion, however, did not show any association with QoL |
| Nickerson, Steel, Bryant, Brooks & Silove (2011) | To investigate whether a change in visa status from temporary protection visa (TPV) to permanent visa (PV) would | Australia | Mandean refugees n = 101<br><br>TPV status at first data collection n=72 | • Harvard Trauma Questionnaire (Mollica et al., 1992)<br>• Post Migration Living Difficulties (Silove et al, 1997)<br>• Mental health related QoL – Medical Outcomes Study (SF-12; Gandek, | • Change in visa status related to decrease in PTSD symptoms ($p<.001$)<br>• Change in visa status related to decrease in living difficulties | • Did not account for those who may have had therapy which could have reduced symptoms.<br>• Passage of time may have reduced |

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| | affect the trajectory of mental health and living difficulties. | | PV at first collection n=29<br><br>Initial data collection 2006-07, and follow up in 2008-09<br><br>Reported in previous study | 1998)<br><br>• Mediation analysis | (p<.001)<br>• Change in visa status significantly related to increase QoL (p=0.016)<br>• Change in living difficulties or QoL were not related to living difficulties | symptoms also.<br>• Did not account for time in the country which may have effected results<br>• More definitive impact on visa change cannot be determined from this study. |
| Stack & Iwasaki (2009) | To explore the role of leisure pursuits among Afghan refugees which may promote better health and life quality | Canada | Sample n=11<br><br>Moved to Canada in last five years<br><br>Men n=4<br><br>Women n=7<br><br>Age range = 19-60 | • Semi-structured interviews.<br>• Script with open-ended questions<br>• Questions included:<br>– How do you enjoy spending your spare time?<br>– Do you feel that you benefit from leisure activities? If yes, what do you think the benefits are?<br><br>• Phenomenological analysis | <u>Themes:</u><br><br>• Socially Constructed Forms of Leisure – leisure can be purposeful and meaningful, facilitating connections to family friends and community<br>• Benefits of Leisure: Contributions to Education, Learning and Development – enable to establish lives for future | • Use of bracketing to set aside prejudgement or assumptions<br>• Stated ethnic background of researchers<br>• Journal used to assist analysis<br>• Generalisations limited<br>• Snow-ball sampling approach and therefore potential sampling bias |

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| | | | | | success<br>• Adapting to Immigration and New Environment - barriers and challenges over time | |
| **Section: Refugee Experience for Treatment of PTSD** | | | | | | |
| Crumlish & O'Rourke (2010) | Review of PTSD treatment for refugees | Ireland | N/A | • Systematic Review<br>• Academic Search Premier, Allied and Complementary Medicine, Cochrane Central Register of Controlled Studies, CINAHL, EMBASE, Entrez-Pub-med, Psycinfo, and Web of Science | • 10 trials met inclusion criteria, and trial interventions included:<br>• Exposure therapy vs. TF-CBT<br>• NET<br>• CBT<br>• Manualised NET | • Treatment amongst refugees for PTSD has no solid evidence base<br>• NET appeared the best supported treatment modality with three high quality trails moderately supporting use of NET<br>• TF-CBT had one trial of moderately high quality in support. |

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| | | | | | | • No overall effect size obtained |
| McPherson (2012) | Literature review to answer eview question of whether NET may reduce PTSD in those who experience mass violence and torture | USA | N/A | • Review<br>• Searches of Cochrane Library, Psycinfo, Medline and PubMed | • Eight studies selected<br>• Good evidence to support NET<br>• Studies had good study design<br>• Limited by small samples<br>• Good treatment fidelity | • Due to heterogeneity no meta-analysis was completed |
| Palic & Elskit (2011) | Review of the knowledge of treatment outcomes for traumatised refugees | Denmark | N/A | • Systematic Review<br>• Psych-INFO, Pub-Med/Medline and PILOTS | • 40 studies covering<br>• CBT<br>• Multidisciplinary treatments<br>• Treatments other than CBT | • Implications for efficacy of standard CBT, particularly culturally sensitive CBT for Southeast Asians and Narrative Exposure Therapy<br>• More needs to be done if to treat more than PTSD symptoms<br>• Longevity of |

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| | | | | | | treatment effects poorly researched |
| Robjant & Fazel (2010) | Exploration of the evidence base for MET | UK | N/A | • Review<br>• Searches of Medline and Scopus for published NET research | • NET shown to be effective amongst individuals who have experienced multiple trauma<br>• Trials have shown a reduction in PTSD symptoms, which further improve at follow up<br>• Limited evidence of co-morbid conditions improving | • Small evidence base (with participant numbers also small)<br>• Suggested can be used as part of a treatment package |

**Summary Table of Theoretical Papers**

| **Author** | **Brief Overview** |
|---|---|
| Berry (1997) | The author outlines a framework by which to investigate acculturation and adaptation. Four key processes are described which are assimilation, separation, integration and marginalisation. |
| Bhugra & Becker (2005) | Authors propose mental health practitioners should be aware of the stressors and cultural aspects of immigrants and refugees. Explores the |

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| | relationship between cultural bereavement, cultural identity and cultural congruity. |
| Chantler (2011) | The author highlights the importance of a social model of understanding mental distress to include uncertain immigration status, as PTSD is currently conceptualised from a Euro-American, bio-psycho-social perspective. |
| De Vries & Van Heck (1994) | Authors state most QoL instruments are Western, and refugees are from non-Western countries. Limited refugee research on broad spectrum of QoL, and a specific instrument for refugees |
| Douglas (2010) | Author states losses may be traumatic, with the possibility of survivor guilt i.e. belonging to a particular political group or marrying to a person of different ethnicity |
| Eisenbruch (1990) | Author states cultural bereavement may be important to understand subjective responses to trauma by structuring reactions to loss in cultural specifics such as how a person expresses distress. |
| Fullilove (1996) | Author describes the psychological process which are affected by geographical displacement named 'Psychology of Place'. Key aspects of attachment, familiarity and identity, which are threatened when displaced and lead to nostalgia, disorientation and alienation. |
| Hollifield et al (2002) | Authors review QoL to date and illustrate limited validity and reliability for refugees. Lack of theoretical base which requires addressing. |
| Marsella (2010) | Author provides an overview of the ethno-cultural aspects of PTSD. The author proposes ethno-cultural variables may influence the perceived causes, symptom manifestations, onset, course and outcome of PTSD |

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| Padilla & Perez (2003) | Author expresses importance to see inter-cultural contact through a social framework, and includes exploration of social identity, social dominance and cultural competence |
| Riedel Wiess & Hannich (2011) | Authors propose a framework which incorporates Berry's acculturation model, Antonovsky's salutogenic theory (sense of coherence), to enhance the link between culturally associated stress and mental health. I.e. those with a strong sense of coherence should psychologically adapt better in a new country. |
| Silove (1999) | Author proposes a model whereby torture and related abuses may challenge core adaptive systems such as safety, attachment, justice and identity role. |

## Appendix Three – NHS Ethics and Local R& D Approval Letters

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## Appendix Four – Interview Schedule

**<u>Narrative Interview Questions for Major Research Project</u>**

- What has your life been like since you arrived here?

- What has it been like for you being a refugee here?

    - (Prompt)What experiences have been better than expected here?
    - What experiences have been worse than expected here?

- How have you coped with living in the UK?
    - (Prompt) What things have been easy to cope with here?
    - (Prompt) What things have been hard to cope with here?

- What was it like to be given a diagnosis of post traumatic stress disorder?

- What was your experience of applying for leave to remain?

    - (Prompt) How did the application process affect you?
    - (Prompt) How did the process affect how you feel about yourself?
    - (Prompt)What things helped you through it?

- What has your life been like since you were granted leave to remain?

- What were your hopes when you were travelling to this country?

- What are your hopes now?

- How do you see your future here?

## Appendix Five– Participant Information Sheet

# Participant Information Sheet

# An exploratory study of the experience of Quality of Life for refugees

I would like to invite you to take part in this research study. Before you decide whether you would like to take part or not, please read this information sheet to help you make your decision.

Your clinician can go through the information with you and answer any questions you might have. This information will take about 15 minutes to go through, and if you would like to talk to someone outside of the [REMOVED] team about the study, please do so.

Part One of this information sheet tells you the purpose of the study. Part Two tells you information about how the study will be done.

**PART ONE**

**What is the purpose of the study?**

This study aims to look at your experience of being in this country since you arrived here. This will be done by interviewing you.

The interview aims to highlight your current quality of life and take into account the symptoms you are experiencing because of the traumatic experiences you have had, being given a diagnosis of PTSD, and being a refugee in this country.

This will hopefully provide new ideas which may help to improve treatment for post traumatic stress disorder in the future for refugees.

**Why have I been invited?**

You have been invited as you meet the criterion to participate in this study. These include that you are a refugee, a service user of the [REMOVED], and you have a diagnosis of post traumatic stress disorder.

**Do I have to take part?**

It is up to you to decide whether you would like to join the study or not. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form.

You are free to withdraw at any time, without giving a reason.

**What is involved in taking part?**

Once you have given your consent to take part in the study, you will be asked to arrange a time with the researcher for an interview. The interviews will take place at the [REMOVED]. The interview will last for approximately one hour.

If you require an interpreter, this can be arranged for you by the researcher and will be from [REMOVED].

With your consent, the interview will be audio-recorded. The interviews need recording so I ([REMOVED]) can type up the interview as a transcript, and use this to complete the analysis of the information you provide.

You will not be identified from the interview transcripts or in the write up of this research.

There is no follow up planned for this research study and you will only have to participate once. If you wish to take part in the study, please inform your clinician when you next attend the [REMOVED] for your appointment.

**Expenses and Payment**

You will be paid your travel expenses in cash for attending the interview. Please ensure that you keep your receipts for travel. If you have an Oyster card, please let us know where you have travelled from, to ensure we calculate the amount you will be paid correctly.

**What will I have to do?**

You will be interviewed by [REMOVED] (the researcher).

I will ask you questions about your life in the UK, and about your diagnosis of post traumatic stress disorder, which I would like you to answer as fully as you can.

We ask that you are open and honest with [REMOVED] in the interview. It is up to you what you talk about. If, however, there is something you do not wish to talk about or you find too distressing, please let [REMOVED] know.

You may stop the interview at any point. Alternatively, we can take a short break until you feel ready to continue.

After the interview has finished, I will ask you what you thought about the interview, and find out if there is anything I could have done differently to improve the interview for other participants and to clarify anything you may wish to discuss about the interview.

**What are the possible risks or disadvantages in taking part?**

It may be that during the interview some difficult times or memories may be talked about. If you have any concerns about this, please speak to the researcher or your clinician at the [REMOVED] before you give your consent to take part.

What you talk about in the interview will not be communicated to anyone else. The information you provide cannot be used for any legal purposes. The researcher cannot write any legal reports or represent you in any way.

**What are the possible benefits of taking part?**

The possible benefits may be that you have an opportunity to share your story of your life since you arrived in the UK, adjusting to being here, how you have coped with experiencing PTSD, and your hopes for the future. These are things you may not have had an opportunity to share yet.

It is hoped that your stories will assist clinicians in treating post traumatic stress disorder for refugees (and asylum seekers), through a better understanding of your experiences and needs.

**Will my taking part be kept confidential?**

We will inform your care co-ordinator and clinician at the [REMOVED] that you are taking part in the study.

The information you share in the interview will not be part of your therapy, and your clinician will not know what we have discussed.

The information you provide will also be stored separate to your clinical notes held by the service. If any risks (to yourself or to others) become apparent from the interview, I will discuss this with you and I am obliged to inform your clinician at the [REMOVED] to ensure your safety.

**PART TWO**

**What will happen if I don't want to carry on with the study?**

If you wish, you may withdraw from the study at any time.

If you decide not to carry on we will ask you if it is OK for us to use the information already collected from you. If you would not like the information to be kept, we will remove all information confidentially from the study.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the [REMOVED] and I will do my best to answer your questions on [REMOVED].

If you remain unhappy and wish to complain formally, you can do this by contacting [REMOVED]

Address: [REMOVED]

**Will my taking part in this study be kept confidential?**

The information you provide to the study will be kept strictly confidential.

The information collected from the interview will be kept securely, and handled by the researcher only.

The audio recording and typed transcriptions will be kept on a secure password protected USB key drive so no-one else will be able to read them.

The recordings of the interviews will be permanently deleted after they have been transcribed.

The transcriptions of the interviews will have all identifiable information removed and will be referred to numerically. Any quotes used from the interviews in the write up of the research will have all identifiable information removed.

Once the study is complete the information (anonymous transcripts and the write up) will be destroyed after 10 years. During this time the information will be kept at [REMOVED] in a locked cabinet.

You will not be able to be recognised from the information you provide.

**Involvement of Family Doctor or GP**

Your family doctor may not be aware that you are taking part in the study, but your clinician at the [REMOVED] will. If you wish for your GP to be made aware, please let us know.

**What happens to the results of the research study?**

The information collected will be analysed and used to write up the researcher's clinical psychology doctorate thesis.

The study will also be written up for publication.

If you would like to know the results of the study, please inform a member of staff at the [REMOVED] or the interviewer.

**Who is organising and funding the research?**

The research is supported by [REMOVED].

Funds have been provided by [REMOVED] to pay you your travel expenses.

**Who has reviewed this study?**

The study has been reviewed by [REMOVED] and approved by NHS Ethics.

**Further Information and Contact Details:**

[REMOVED]

Email: [REMOVED]

Telephone: [REMOVED]

**Appendix Six – Consent Form**

## Consent Form

An exploratory study of the experience of quality of life for refugees

**Centre:** [REMOVED]

**Participant Identification Number for this study**:

**Name of Researcher:** [REMOVED]

I confirm that I have read and understood the information sheet dated.................... (version............) for the above study.

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical, or psychological care or legal rights being affected.

I agree to my care co-ordinator or responsible clinicians being informed of my participation in the study.

I agree for my interview to be audio-recorded.

I agree for quotes to be used from my interview in the write up of this research. All quotes will have all identifiable information removed.

I agree for the researcher to contact me on the details I give below to arrange a date and time for the interview.

I agree to take part in the above study.

Name of Participant ______________________________________________

Date ___________________________________________________

Signature ______________________________________________

Contact Details: ______________________________________________

Name of Witness________________________________________________

Date ____________________________________________________________

Signature of Witness ___________________________________________

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

## Appendix Seven - Research Diary Extracts

**17th October 2011**

Beginning the literature search and starting to write the literature review, has been difficult, particularly trying to condense the information and pulling the diverse information and research together. This seemed to be reflected in the clinical work with traumatised asylum-seeking and refugee clients, and their struggles to make sense of their experiences. It seems that time and space are needed in order to for clarity to develop, hence the literature review may take considerable time to piece together to develop a more coherent and contextualised whole.

**6th December 2011**

Completed the first interview today. The participant developed a narrative from the initial question, and gave a full, descriptive account of his life since he arrived in the UK. I felt drawn in by his narrative, and at times, it was difficult to remain in the researcher role due to the intensity of the narration and his comparison of his experience in the UK with his home country. The statement of 'emotion torture' seemed to resonate with another client I had seen who had used this term in a clinical setting. The interview felt quite stuck in places, and the recollections of events in the participant's home country although were told in a relatively flat tone, appeared to elicit some tearfulness and sadness in the interpreter. This was also felt by me, but was felt in more of a dulling capacity. Although, this participants parents were alive (and he had not experienced any close familial losses), it seemed there was a significant level of loss in the narrative, which seemed related to his personal history and that of being a child. Appeared somewhat regressive in this sense, but the monotony of it felt continuous. Seemed to experience loss of home, and required containment.

**13th December 2011**

Interview with second participant. This interview felt more difficult to elicit a narrative as far more prompts were used to elaborate the narrative. It was not necessary to ask all the questions, however, but it seemed that as the client was so keen to communicate a balanced perspective of his life in the UK, and his experience of kindness, that he did not wish to dwell or elaborate on the times when life was more difficult for him. His manner, however, was warm, and it seemed he was also keen to help in any way as he expressed a sense of indebtedness. This interview was a stark contrast to the first, and it left me thinking whether all of the interviews could be this diverse from one another, and questioning how this may be reflected in the analysis.

**10th January 2012**

Third interview completed, and was the longest so far. This interview seemed to revert back to being much more of narrative, with minimal prompt questions from me. Again the word 'emotion torture' was used and appeared to enunciate his feelings of profound difficulties.

Interestingly, this participant spoke little of his physical health difficulties, which were a regular theme of the clinical sessions. However, I was unable to ask more about this, and I felt more aware of knowing his history and current problems, but did not question this to deflect his narrative in any way. Again, I felt myself being pulled into more of a therapist role, and struggled a little, particularly as the participant had known me previous to the interview. The participant came across as very stuck, and this was felt within the interview, and a real sense of not being able to move the client on to the next phase, and with real difficulty contemplating what his future may be. His future felt very conditional and aligned with his expectations of what life would be like in this country, but also not thinking or feeling that this could be possible adding to his sense of stuck-ness. Clearly affected by traumatic loss of attachment figures- prolonged grief?

**16th February 2012**

Fourth interview. This was the shortest interview yet. The participant was interviewed in the presence of her young baby and so was unsure how much of the effected the interview process. Again, this interview seemed to require more prompt questions, and the narrative was quite limited at first. However, this seemed to ease and flow the longer the interview progressed. The length of time for the participant was very short in comparison to the sample thus far (approx. 2 years), and also the asylum seeking process was significantly different., possibly due to trafficking and different legislation and practice for women who have been trafficked into the country. There seemed a real sense of hope and freedom within this interview. The participant laughed regularly throughout, and expressed a renewed sense of hope and purpose. I came away from the interview feeling quite uplifted and positive, which again is a stark contrast to how I felt with other interviews previously. Improved sense of coherence from intervention?

**29th February 2012**

Fifth interview completed. Slowly getting there. Recruitment has been a tougher than originally thought. Although it seemed there may be plenty of participants, it seems quite a few who could be suitable have not yet been granted leave to remain.

This interview was longer than previous (approx. one hour). Again, a narrative was clearly developed form the opening question, with little prompting required. The participant appeared very open and frank about his experiences, and came across as positive and strong. I'm not sure how much of this is connected with the completion of a trauma-focused intervention. However, the previous participant had also completed an intervention, and so there may well be a connection here. The participant appeared hopeful about his future, but there seemed a little bit of anxiety connected to finding his family, and want to know how they were. The narrative built up from a stressful beginning, although his period of homelessness was limitedly narrated, to a positive end, and a sense of this being quite a linear narrative within which the narrator had to work significantly hard to reach the point he is at now. I left the interview feeling accomplished, not only as a sense of this from the client, but also in terms of eliciting a narrative which although contained some stressful moments, appeared to be well contained. How much of this was due to therapy, and my own research interview skills I'm not sure yet. I will have to wait

and see for the next interview to test this out possibly. A clear role for the psychology service, and psychological therapy, and a real sense of finding others who have been able to support him in any way, and wanting to help others because of this.

**15th April 2012**

I have begun to work more on completing typing the transcriptions ready for the analysis, as this seemed a productive way of making use of time before the next round of interviews. Am slightly concerned about having too few participants, but I remain hopeful as am assured by clinicians that there are suitable clients to take part.

I initially began transcribing as I was completed the interview, however, I stopped as it seemed to be quite emotionally draining. It became a very emotional process, and whilst on the PTSD placement, it felt particularly overwhelming to do this, and so I (perhaps unconsciously at first), decided to wait until I had completed the placement.

It feels as though some of the transference and counter-transference in the interview is laden in the recordings. It may be that I was more defended against this, or was protected in some way by the clinical setting and space which meant I did not feel these emotions so strongly. There may also be something about the (or my) role of a psychologist and/or researcher, which meant I was able to focus the asking the right questions, staying in the moment, or being a container for the participant. I feel as though a lot of painful emotional processing and expression has taken place, and I am glad to have waited until now to have completed it.

**26th April 2012**

Analysis. Feels a bit of a struggle to find my way through the narrative research literature. Developing a plan of what to analyse and how was particularly useful as the thematic analysis seemed insufficient to truly attempt to address the research questions, particularly as the narratives appeared to be complex from the reading through and listening to the recordings. When I began immersing myself in the data, I felt particularly stuck with participant one, and it was difficult to come out of this feeling, as the narration felt thick and laden with suffering. It made me think about whether asylum-seeking could be conceptualised as trauma in itself, but also the devastation of the attachment with his family being forcibly ruptured, and the effect of this. Participant two's narrative was much more straightforward, with clear repetitions throughout. The clarity of the narrative may have been linked to the narrator's ability to strike a balance between the good and bad experiences, and locating the examples of this with his physical health, rather than his mental health.

**4th May 2012**

*Research Meeting with Supervisors*

I shared my initial analysis of participant one and two at this meeting using the analysis sheets I designed. I also shared my initial confusion and anxiety about the finding the appropriate

methodology to analyse the data, however, once explaining what I had done, all agreed this appeared the most appropriate way of addressing the research questions.

Interesting conversation regarding participant one, and the strong emotional transference, and whether this was the participant's way of communicating how much they had been through, and sharing feelings of 'torture'. Even within the meeting this felt quite emotionally charged. However, was this was thought to be useful to the process of analysis.

The interpretations I had made regarding his family appeared similar with my supervisor's experience of the client. It was suggested that expectations may also be linked with certain cultures, and their view of what life is like in the UK. However, we all became aware of how this conversation may add further data to the analysis, and as such we agreed for this conversation to be continued once the data and all analyses had been completed in order to stay true to the data.

**17th May 2012**

Sixth interview completed. The participant seemed quite reluctant to be audio-recorded, although agreed. This interview was also completed in the presence of her young daughter, which meant she was unable to talk about events or feelings that may have been more difficult. This seemed quite a grounded interview, and the narrative was elicited and developed from the opening question. Again, it seemed the interview was quite focused, and with minimal prompting questions needed.

The participant spoke openly of her difficulties whilst asylum-seeking, and although received leave to remain, it felt there was quite a long way for her to go on her journey to rebuild her life. Interestingly, the participant spoke at some length after the audio-recorder was turned off. This seemed to be linked with talking more explicitly about the Home Office, and it was clear she did not wish for this to be part of the recorded narrative. The participant encouraged me to support clients, and I am left with a feeling of unfinished business. I feel as though there is more I could write, which I have not been drawn to do after other interviews. I was left thinking about how she was feeling after the support she had from the psychology service, and solicitor had finished, and whether she wanted some other contact. I'm not sure what this is in response to, and whether this may be connected with the sense of loneliness from the participant, or whether this is connected with her describing being an orphan and always being alone.

**31st May 2012**

Seventh and final interview completed. This interview was quite succinct, although initially he was reluctant to narrate his asylum-seeking process. This seemed to be linked with his evaluation of asylum-seeking being the worst period of his life. It also seemed that he thought this was something I could not understand as I had not been through it, which left me feeling pushed away. However, this eased by the end of the interview. His experiences seemed linked with his expectations of life in the UK, and this having an impact on his level of satisfaction with life. This also seemed tied in with the significant loss of his wife (romantic attachment), and possible prolonged grief?

On completing data collection, my initial thoughts are that QOL has not been expressed in the narratives. In the same way it is put forward by the QoL measures. The WHOQoL may come closest to their experiences, but still seems limited. Life satisfaction may be low inherently in this population, which could be connected with significant loss, grief. There seems to be a struggle in developing meaning and sense of their experiences in the context of these significant losses, which may impact on their satisfaction or psychological health.

**8th June 2012**

*Research Meeting with Supervisors*

The analyses were completed by the meeting. Both supervisors had read through the transcripts and analysis I sent them, and fed back. There was plenty of interesting discussion around the performance of the narratives, and the links between personal histories. E.g. a sense of loneliness from an orphan or the expression of human rights and democracy as a way of holding on to deceased parents (which may exacerbate grief).

The themes and structural analyses for each participant were discussed in relation to the research questions, and how this could be explored for each case before bringing this together to create a coherent representation. This was posed as quite difficult as the relationships between PTSD, QoL and migration appear to be patchy when looking at the individual cases.

Thoughts were shared around the experience of asylum-seeking being construed the same as the experiences in the participants home countries, and the sadness of this. We also explored how PTSD may be suppressed initially in the narratives, and the lived experiences, as it appeared later in the narratives. We discussed how QoL may be linked with support and the particularities of this for refugees and asylum-seekers.

**21st June 2012**

Writing up results is quite useful in terms of processing the data further and pulling everything together. It is pleasing to see the results fit into existing theory and research, such as complicated grief, loss of home, social support and its effects on PTSD. I question the relevance of sense of coherence, which seems to fit quite well with the refugee experience. The participants' expressions of separation, brokenness, suffering, the incomprehensibility of their troubled lives and what they can/could deal with compared to life before the traumas, seem to indicate this theory may be relevant for traumatised refugee. For those who have completed psychological therapy had it facilitated re-building a sense of coherence? I.e. expressing ability to progress

## Appendix Eight– Example of Narrative Analysis Form

| **_Participant Number_** | |
|---|---|
| **_Notes from Initial Readings:_**<br><br>_What is narrated?_<br><br>_What are the main points?_<br><br>_What propositions are made about self (identity), culture, host country?_<br><br>_What emotions are expressed_<br><br>_What is expressed about PTSD?_<br><br>_What is expressed about QoL?_<br><br>_What is expressed about migration status/experience of migration?_ | |
| **_Overall Structure_**<br><br>_How is the narrative organised?_ | |
| **_Form of the Narrative_**<br><br>_What is the tone within the narrative?_<br><br>_Where are the shifts?_<br><br>_Researcher's subjective responses?_<br><br>_How is identity expressed? Is this tied in with the narrative shifts?_<br><br>_How is QoL expressed? How is this tied in with shifts?_<br><br>_How is PTSD expressed?_<br><br>_At what point is PTSD expressed?_<br><br>_How is migration status expressed? Does this fit with shifts in the narrative?_<br><br>_How has the person used the structure to make meaning of their experience?_ | |
| **_Performance_**<br><br>_How is the narrative performed?_<br><br>_What preferred identity is the person expressing?_ | |

## Appendix Nine - Example of Initial Codes for Participant Five

| | | | | |
|---|---|---|---|---|
| 'Step by step' | 'Little bit' | Support | Friends | Support from solicitor |
| Support from GP | Trouble (in UK and in Home Country) | Struggle | No reason/Reason | Refused |
| My mind | 'Hiding' | Bad dreams | Noise | Memory |
| Family | Dissociation and disorientation | Time (Months, years, days, weeks) | Acceptance | Home Office |
| Being believed | Language - Interpreter | Pass the step | Clear the step | Watch your step |
| Always moving | Homelessness | 'Fight' for your mind | Strong | Advice |
| Medication | Lucky | Support from psychology | Trying to forget | Heaviness |
| Difficult | Money (benefits), housing, bed | Sleep (difficulty sleeping) | 'Lost' | Leave to Remain (process) |
| Confidence | Sharing | Trust | | |

**Higher Level Codes for Theme Development**

***Acceptance*** – Elements of passivity or someone else in control, 'OK' I said 'OK' 'I continued' in the context of acquiring leave to remain, application refusals, no reason, no questioning,

***My mind story*** – 'Hiding', bad dreams, memory, noise, dissociation and disorientation, treatment, struggle, trouble (home country and UK)

***Step by Step*** – support from friends, clearing the steps to move on to the next step, the next 'big step' (Hopes for the future), steps from the past,

***Strong –*** Have to be strong, 'fight' for your mind, be strong otherwise will lose your mind, 'little bit strong'

***Support*** – From friends, from the GP, from psychologist, from solicitor, from professionals, people you can trust, help me to pass the step, money support, housing support, advice

***Home Office*** – Interviews, discrepancy between experience of interviews, 'nice', 'confident' and outcome – 'refused' and 'no reason', being believed

***Time*** – 9/11, every [REMOVED], one month, two month, two/three days, provides temporal context

**<u>Final themes</u>**

**Passive Acceptance**

Elements of passivity or someone else in control, 'OK' I said 'OK' 'I continued' in the context of acquiring leave to remain, application refusals, no reason, no questioning. L Largely in relation to interviews, discrepancy between experience of interviews, 'nice', ' 'refused' and 'no reason', seemingly unfathomable (but questioned by others not narrator), 'believed'

**My Mind Story**

'Hiding', bad dreams, memory, noise, dissociation, treatment, struggle, trouble (home country and UK).medication not helping. Incorporates Have to be strong, 'fight' for your mind, be strong otherwise will lose your mind, 'little bit strong'

**Step by Step**

Clearing the steps to move on to the next step, the next 'big step' (Hopes for the future), steps from the past, Incorporates support from friends, from the GP, from psychologist, from solicitor, from professionals, people you can trust, help me to pass the step, money support, housing support

***Time*** has a function in the narrative and seems to be used to provide temporal structure.

## Appendix Ten – Example Transcript: Participant Five

*This has been removed from the electronic copy*

## Appendix Eleven - Tabulated Cross-Case Analysis

### Thematic Analysis

| Themes | | | |
|---|---|---|---|
| **The Legacy of Asylum Seeking** | **PTSD** | **The Journey of Recovery** | **The Importance of Support** |
| His expectations were not met and so he feels a relentless sense of suffering and continual torture. He described feeling imprisoned within himself, but yet also feeling numb and not caring. It seems the asylum seeking and refugee processes are intertwined, seemingly making it difficult for him to make sense of what is happening other than suffering. | PTSD is spoken about in term of flashbacks, 'everything came out', 'daydreaming', and rumination. A sense of the never-ending memories of [REMOVED] and what happened to his friends and family, and the wrath of the all consuming '[REMOVED] devil'. | He describes himself as 'equal' now he has achieved leave to remain and throughout gives examples of being on the 'right' and appealing and contesting decisions made about his physical health diagnoses and benefit decisions. He expresses gratitude throughout for the positivity and 'luck' that has come his way. He compares himself with others who have experienced greater negativity, and is able to construe that he is more fortunate. | Throughout the narrative the participant describes occasions of encountering kindness, generosity, sincerity, and being made to feel special both from those from his own culture and English people. He spoke of a circle of friends who welcomed him, supported him, provided him with companionship and became like family. The experiences he has had seem connected with wanting to return the kindnesses, particularly as he has been granted the freedom he desired. |
| There are consistent references throughout the narrative of life remaining the same since the loss of his family –He refers to experiencing torture both in the UK and in [REMOVED]. These | The narrator mentions quite early in the narrative about his 'mind story' however, this is not explored further until a third into the narrative. When the narrator does express this, he speaks of 'bad | She spoke of the difficulty with finding out she was pregnant, and not knowing who the father was. However, she spoke of gradually *'letting go'* and relying on her faith to get her through the difficult | The narrator talks of the help and support she has had from the psychologist, psychiatrist, the lawyer, the social worker and also her friend who signposted her to enable her to gain access to the |

| | | | |
|---|---|---|---|
| experiences although different ('*physical torture'* in [REMOVED] and '*emotional torture'* in the UK) seem entwined and difficult for him to distinguish from one another. The narrator describes his experiences as '*very bad*', '*poor*', '*very very difficult'* and there seems a sense from the narrative of nothing changing throughout his experiences. | dreams', 'noise', 'memory' and 'trouble', wronging his family by leaving them behind, being pushed to do something '*bad to myself*' and disorientation (particularly on arrival). The narrator describes having to hide and '*forget'* his memories of the past, and put it on '*one side'* as he did not want to '*mix it with my situation'* whilst seeking asylum, as otherwise he would have '*lost my mind'.* He talks of being a '*little bit strong',* and having to *'fight for your mind'* in order to survive the '*trouble*', which he also equates with his traumatic experiences in his home country. | moments in her life when she was '*down*' or worried about her [REMOVED] interview and the outcome of this. The passing through was described as '*bit by bit*' and '*little by little*', and her experience in the UK had initially been '*up and down'*. However, she now has a '*new life'* and a '*new purpose'* following being granted leave to remain and the birth of her child. She expressed a commitment to moving on with her life ('*I want to move on'*) | mental health professionals and legal assistance. These characters seem instrumental in helping the narrator to progress through her asylum seeking process and mental health difficulties '*slowly, slowly'*. The narrator speaks of being provided support which facilitated her access to appropriate housing, and evidence to help the [REMOVED] with their decision to grant leave to remain. |
| The narrator spends much of the narrative expressing the stressfulness of asylum seeking. She states throughout it is '*very very difficult*', it is '*not good*', it is '*very terrible'* and '*very, very hard'*. She also states it is the '*hardest thing'* she has seen despite her life not being '*easy*' for her since childhood. She | The narrator clearly speaks of her experience of PTSD and the symptoms of PTSD such as 'flashbacks back home', 'can't sleep', 'sweat' and her 'heart pumping'. She talks of this also in the context of seeking asylum and waking up at night anxious about possibly being deported. She talks quite hauntingly of | The narrative documents quite systematically and with the use of regular, accurate temporality, the struggles of the narrator from his arrival up to the present. The '*step by step'* analogy comes through early in the narrative, and seems to illustrate the approach he has taken towards the | Feeling lost and having no-one to turn to, or rely on at this time of constant suffering. Feeling that he needs more support now than he did when a child. There seems to be nothing which provides him with containment or an environment whereby he feels looked after (which he had experienced whilst in |

| | | | |
|---|---|---|---|
| states the most difficult things were not having somewhere to live, and not knowing anybody she could turn to, and ask for help. | times of being alone and in quiet and the PTSD 'coming out' which is why she was thankful for her children keeping her 'busy' in order to prevent this. She also talks of the medication prescribed to her which has helped to manage these symptoms. | application process (encompassing the acceptance and persistence to move forward), through to the treatment of PTSD, and the '*next step'* to achieve of reconnecting with his family. He particularly, describes struggling with the beginning of therapy and initially feeling worse, however, he is driven to continue attending with the resolve that he should persist as he was reassured he '*will be OK'* and that '*this is the only way'* for him to be '*more better'*. | the detention centre). |
| The narrator talks of seeking asylum as '*stressful'*, '*difficult*', and the '*worst memory'*. He states that he never imagined people could go through such a horrible experience, filled with, '*uncertainty*', '*unease*', depression and anxiety. This difficult period also seems linked with his imagination of what life would be like on arrival in the UK and the lived reality which did not match up, and are indeed far away from one another. | | The narrator speaks repeatedly of working hard, trying to get better, to '*get over this'* and to '*get on with life',* all of which he seems to talk about with some pragmatism. He narrates this will be a long process, and although he expresses he is unsure of what his future looks like, and he wonders whether he will be able to 'forget' his past; he remains hopeful with '*light at the end of tunnel'*. There is a sense the he is '*slowly, slowly'* rebuilding his life | Support seems to have come from 'friends' he has met along the way, who are not described as close friends, but people who have provided him with a place to stay and from professionals who have helped him. From this support his basic needs (e.g. a place to stay) were met by the 'friends', and assistance to acquire leave to remain, from which he eventually gained access to benefits and housing. His progress seems firmly connected with the support he has |

| | | | |
|---|---|---|---|
| There is a sense that his difficulties have not diminished from being grated leave to remain. He states that he '*wouldn't have chosen to live this way*', that his life '*fell apart*', and that he lives an emotionally, mentally and bodily '*poor life*'. | | from the beginning; for which he has had to learn to accept this life which he would not have chosen for himself. He speaks of some hopes to study again and to relax, and an aspiration to be '*like a normal person*'. | received on his journey to refugee status, and he acknowledges that people have supported him to '*pass the step*'. |

**Cross-Case Structural Analysis**

| Participant | Overall Structure | Progression | Stability (Positive) | Stability (Neutral) | Stability (Negative) | Regression |
|---|---|---|---|---|---|---|
| 1 | Negative Stability | **Progression** seems to be linked with a period in detention centre whereby the narrator feels **contained, looked after, has access to amenities, is educated**, **acknowledgement of entitlement, small glimmers of hope** | | | **Negative Stability** linked with **traumatic memories in home country (experiences are tied in with asylum seeking), identity as a man (child) who is suffering (tortured), sense of entitlement( I don't get/have not got what I am entitled do) and expectations of host culture and how he should be treated** | Regression linked with **being pushed out of detention, expressions of PTSD, encountering rudeness, hostility, being pushed out by family.** |
| 2 | Progressive | Progression linked with **acceptance from others, kindness, friendship and family relationships, closeness and connections with** | | Neutral Stability linked with mantra of **not being a liar or a bogus, on the 'right side'** | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | **others of a similar background, narrators values, strong sense of identity, I have had a 'good outcome' - freedom** | | | | |
| 3 | Negative Stability | Progression linked with **accessing health care** | | | Negative Stability linked with **search for meaning, current suffering (torture), achievement of a new life being both easy and difficult, ideals, expectations not met and a sense they will not be met at all** | Regression linked with **being declined for healthcare (due to asylum seeking status), trying to make sense of his experience, moving continually (no stable place to be), PTSD** |
| 4 | Progressive | Progression linked with **treatment completion, being independent, happy and with a free mind, claiming benefits, education, being a 'new me' with a 'new purpose'** | Positive Stability linked with **faith, strength of faith and strength** | Neutral stability linked with **balancing out of her narrative – I have not passed through as much as others** | Negative Stability linked with **PTSD, expression of not fully understanding PTSD** | Regression linked with **beginning of treatment, searching for meaning of her experience and that of others** |

| | | | | | | |
|---|---|---|---|---|---|---|
| 5 | Progressive | Progression linked with **step by step journey, clearing the step of PTSD, treatment, support from professionals and people who have helped along the way, access to benefits and housing, desire to work and 'be normal' and to clear the next step, narrator's strength** | | Neutral Stability linked with **asylum seeking process (others search for meaning on narrators behalf)** | Negative Stability linked with **comparison of experience of home country to experience in UK as an asylum seeker** | Regression linked with **leave to remain (initially as does not provide clarity), back in 'trouble', made homeless, extensive homelessness, PTSD (lack of control of symptoms)** |
| 6 | Negative Stability | Progression linked with **life after leave to remain - 'life is going well' and a little bit better, hope for the future, education, support from others (friend and professionals), reports written as evidence for leave to remain, good lawyer (access to housing and social worker)** | | | Negative Stability linked with **life in the UK being stressful, asylum seeking, life going 'around, around, around' and asylum seeking being the 'hardest thing'** | Regression linked with **PTSD, being alone and quiet, uncontainable, being an orphan, asylum seeking, sadness,** |
| 7 | Negative Stability | Progression linked with | | | Negative Stability | Regression linked |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | **treatment (medication and psychology), support for Home Office to take notice, acceptance, understanding, trying hard to get better, hope** | | | linked with **asylum seeking, life remaining fallen apart, being confused about the future, difficult period of my life, living a poor life, brought back to life with difficultly,** | with **uncertainty, anxiety, depression, PTSD, hopes and expectations not met, life not being as he imagined, no control, lack of agency, 'forced'** |

## Appendix Twelve - NHS and Local R&D End of Study Letter

[REMOVED]

[REMOVED]

Friday, 31 August 2012

[REMOVED]

**END OF STUDY REPORT**

**REC REFERENCE:** [REMOVED]

**STUDY TITLE:** **An Exploratory Study of the Experience of Quality of Life for Refugees**

I am writing to inform you the above study commenced on 17th October 2011, and was completed on 13th July 2012. This letter is also to inform you of the outcome of this study.

This study aimed to explore Quality of Life (QoL) in the narratives of refugees with a diagnosis of PTSD. The research literature to date has indicated a clearer narrative of the traumatised refugee's post –migration experience is required, and that the concept of QoL requires clarity to ascertain appropriateness of QoL measurement for refugees. Further, there seems limited reporting of the qualitative experience of QoL within refugee post-migration. Therefore the use of post-migration narratives may facilitate the exploration and clarification of the concept of QoL within this population.

Episodic semi-structured interviews were conducted with seven refugees (5 males, 2 females), which aimed to elicit narratives of their experiences since their arrival in the UK. Narrative analysis was used; specifically thematic, structural and performance analysis. This enabled the researcher to elicit core themes from the data, and extract the structure, form and shared and performed identities of the participants. These aspects were collated to explore what the participants communicated, how they communicated their experiences, and how they made sense of their experience in the contexts of PTSD, migration and QoL.

A key finding of the study was that containing, accepting and consistent support from others appeared an important factor within the narratives, namely informal and formal support. The informal support intermittently met the basic needs of participants, whilst the formal support (legal and psychological) provided legitimising and containing support. The latter in particular, seemed to progress the transition from a suffering asylum-seeker to a refugee with feelings of hope, improved QoL and improvements in psychological health. Additionally, completion of psychological treatment seemed to contribute to this progression through and beyond leave to remain being granted. Completion of psychological therapy also appeared to contribute to aspiring towards improving other QoL aspects, such as education and employment.

The results suggested the definition of social support currently ascribed in QoL may not appropriately measure the core elements of social support which appeared to be most relevant for the refugee population in this study (i.e. the most consistent, progressive and valued support was mainly from professionals). Further, there seemed a link between the identity of a suffering refugee and the significant loss of loved ones, which appeared to contribute to a lack of progression, and difficulty with making meaning of their experiences. It has been suggested from this that trauma-focused psychological interventions could incorporate aspects of interpersonal psychotherapy, whereby focus is given to the individual's roles and loss.

Whilst this study did not aim to generalise to the much wider and diverse UK refugee population, it showed some interesting findings. However, the sample for the study was smaller than intended due to difficulty with recruiting more female refugees and time limitations. It also would have been beneficial to have included more female participants to further explore the traumatised female, refugee post-migration experience. The analysis used demonstrated validity, reliability and credibility when compared with psychological theory and previous research, and the findings appeared to begin to form the basis of a model. As such, a grounded

theory approach may have been an alternative methodology to analyse the data to develop a model which could be tested in further research.

It is hoped the study provides a useful insight into the QoL of UK refugees, and the important aspects, which contribute to their progression towards better mental health and improved QoL. It is hoped this research will be published, and in the first instance it shall be submitted to the Journal of Refugee Studies. Information regarding the findings of the study has been sent to the [REMOVED] for dissemination to the participants, if they have consented to receive this.

If you require any further information, please do not hesitate to contact me at the above address or at email address: [REMOVED].

Yours sincerely,

**[REMOVED]**

**Trainee Clinical Psychologist**

# Appendix Thirteen – Journal of Refugee Studies (Information for Authors)

JOURNAL OF REFUGEE STUDIES

## INFORMATION FOR AUTHORS

**Please note that the journal now encourages authors to complete their copyright licence to publish form online**

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Please note the following requirements:

1. Your manuscript should be in Word or RTF format.
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3. A separate file should be submitted as your title page, containing the manuscript title, names and affiliations of all contributing authors, and contact details for the Corresponding Author.
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10. References should confirm to the journal's style (please see 5. References below).
11. Provide a cover letter (in Word/PDF format) to accompany your manuscript submission. Your covering letter should include the following statements:
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    b. I confirm that I have read the Instructions to Authors and that my manuscript complies to the journal's submission guidelines.
    c. I confirm that the manuscript has been submitted solely to this journal and neither the whole manuscript nor any significant part of it is published, in press, or submitted elsewhere in any form, including as a working paper, online, in a journal or a book.
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## 3. DATES

Because of the dynamic nature of many refugee situations, authors are requested, when relevant, to indicate clearly in the text when fieldwork was carried out. At the end of the paper, note the approximate dates when it was written.

## 4. TABLES AND FIGURES

These should be comprehensible without reference to the text. They should be submitted as separate electronic files, one for tables and one for figures, with the desired position of each table and figure indicated in the text. For the style of tables and captions to figures, see papers in the journal's current issue. A resolution of 600dpi is necessary for electronic versions of figures.

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- initials
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- title
- place
- publisher.

Please ensure that all citations in the text appear in the list of references and vice versa.

**LEONG, F. T. L.** and **LAU, A. S. L.** (2001) 'Barriers to Providing Effective Mental Health Services to Asian Americans'. *Mental Health Services Research* **3**(4): 201-214.

**LEVY, S.** (1999) 'Containment and Validation: Psychodynamic Insights into Refugees' Experience of Torture'. In Ager, A. (ed.) *Refugees: Perspectives on the Experience of Forced Migration.* London: Pinter, pp. 237-257.

**ROTER, D. L.** and **HALL, J. A.** (1992) *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits.* Westport: Auburn House.

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